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Sixth Edition

INSURANCE

Its Theory and Practice in the United States

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INSURANCE

Its Theory and Practice in the United States

Sixth Edition

Albert H. Mowbray, Deceased

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PREFACE

Professor Albert H. Mowbray died in 1949, leaving behind him a widely used textbook on insurance, of which this is the sixth edition. The fourth and fifth editions were prepared by Professor Ralph H. Blanchard, who, as editor, had worked closely with Professor Mowbray on the first three editions and agreed with his approach. The new coauthor of this present edition was a student of Professor Blanchard's at Columbia University following the Second World War and first studied insurance using this textbook. Consequently he was extremely honored when he was asked to prepare the present edition.

Professor Blanchard introduced several new ideas in the fourth and fifth editions but retained Mowbray's emphasis on the basic unity of the insurance business. This edition closely resembles its predecessors, but there are some significant differences.

Part 1 has been retitled "Risk, Risk Management, and Insurance" to reflect its increased emphasis on risk theory and risk management. Two new chapters have been added relating risk to statistics and to economics, psychology, and business administration. The chapter on risk management, which first appeared as the last chapter in the fourth edition of this text, has been moved to Part 1. Another new chapter in this part describes methods for handling pure risk other than insurance and loss prevention.

In Part 2 the old chapter on common contract provisions has been converted into a chapter that tells the reader how to analyze an insurance contract. The chapter that formerly discussed only homeowners contracts now covers all major forms of business and family multiple-line insurance.

Parts 3 and 4 include no new chapters, but the insurance finance chapter has been substantially revised.

Part 5 now contains six chapters instead of four. The treatment of the social security system has been extended and there is now a separate chapter on the compensation of motor-traffic victims.

Although the new coauthor was primarily responsible for this edition, Professor Blanchard read the entire manuscript and offered many valuable suggestions. Professor Harold Krogh, of the University of Kansas, also reviewed the manuscript and improved the content and its presentation. Miss Ilona Hanka, assisted by Miss Diane Henderson, typed the manuscript. The coauthor's wife contributed some important editorial assistance and moral support. To these people and to those who contributed to previous editions the authors are sincerely grateful for their assistance.

Ralph H. Blanchard
C. Arthur Williams, Jr.

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1
RISK, RISK MANAGEMENT, AND INSURANCE

Insurance is a social device for eliminating or reducing the cost to society of certain types of risk. This statement requires demonstration and explanation, which it is one purpose of this book to furnish. In order to do so, it is necessary to consider certain propositions in the theory of risk, the connection of which with insurance may not be immediately apparent, but a sound appreciation of which is fundamental to an understanding of the economic significance of insurance. These propositions are discussed in the first three chapters of Part 1. The identification, measurement, and control of *pure* risks is known as risk management. Chapter 4 analyzes the risk-management function and some principles of risk management.

Insurance, the principal tool for dealing with pure risks, is introduced in Chapters 5 and 6. Loss prevention, a second important tool, is discussed in Chapter 7. The other methods of handling risk are treated in Chapter 8.

1
RISK[1]

Risk is uncertainty, and "uncertainty is one of the fundamental facts of life."[2] Out of uncertainty spring discussion, hope, planning, accomplishment, progress. But it also gives rise to dispute, fear, defensive tactics, failure, retrogression. Uncertainty is at its greatest height when, of two possibilities, each is equally likely—consciousness of uncertainty is greatest when one *believes* that either of two possibilities is equally likely.

This distinction between fact and belief is important. We *know* nothing of what the future will bring, but we act on a belief in the future, based mostly on our experience of the past, whether or not we are conscious of the past in making judgments about the future. If we have observed or learned of events constantly recurring in relatively fixed patterns, we achieve a feeling approaching certainty that these events will recur in the same patterns in the future. The greater the number of instances and the less the variability of the pattern, the greater one's feeling of certainty that the events will continue to recur in the same way in the future. Whether the events are peculiar to one's personal life or are phenomena of the universe, the tendency to believe is much the same. One expects weariness to follow effort as darkness follows light.

In some cases one feels certain that events will recur but uncertain about the pattern; for example, that there will be adequate rainfall over a period, but its distribution by days and months may vary. In other cases one feels uncertain about both; for example, whether one will be ill and, if ill, at what stage of life, how long, and how severely.

[1] Much of Chapter 1 parallels Blanchard's discussion of risk in "Risk and Insurance."

[2] Frank H. Knight, "Risk, Uncertainty and Profit," p. 347. *Risk* has been defined in various ways in the literature on this subject. For example, risk is commonly defined as the chance of loss. Insurance men often use the term to mean the concrete thing that is subject to the risk, such as a man or house or ship, on which insurance may be written. For a recent critical analysis of various definitions, see R. M. Crowe and R. Horn, "The Meaning of Risk." While recognizing the merits of other definitions and the limitations of their own, the authors of this text prefer to define risk as uncertainty and to distinguish between the uncertainty that is a state of the world and conscious uncertainty.

Our beliefs, our feelings of certainty and uncertainty, while related to the facts of experience, are subject to the bias of self-interest. And inaccuracy of observation may have a similar effect. We are more intensely conscious of the danger of disability from violent accident than from illness, though illness causes much the greater amount of disability. And there are cases in which the strength of one's desire is so great that personal experience, observation, or statistical data have little influence.

There has been considered the more or less automatic production of beliefs by the facts, real or fancied, of one's situation and experience—conscious beliefs produced by an unconscious process. But, in the affairs of the individual, and still more in the affairs of corporate business and of government, there are beliefs, and actions based on those beliefs, that are thought of as resulting from the careful application of reason to ascertained facts. For example, after gathering and classifying data on the traffic over a given section of roadway, one plans and constructs a new highway, allowing a margin of extra capacity for changes in density. If this work is done by an engineer who has no personal interest in the particular program, it is almost a mechanical process, but even here the enthusiasm of the engineer for planning and construction may introduce a tinge of bias.

The significance of all this is that we react to the uncertainty of situations in which we find ourselves, and also plan for the future, in accordance with our beliefs or our emotions. It is in planning for the future that we calculate, however loosely, the probabilities of various lines of action or inaction, to the extent that we have a choice. And we may plan to meet the exigencies of situations in respect of which we have no choice.

It may be said that everyone hopes to profit from his situation, his activities, or his decisions, using "profit" in the broad sense of achieving satisfaction. Part of his purpose is negative: minimization of dissatisfaction.

The fact that a person is alive makes him subject to uncertainties of health. He had no choice in respect of the situation of being alive, but he may choose how to conduct himself in that situation. Many, if not most, of his decisions will be simple reactions to desires; others will be based on reasoned conclusions from experience, his own or that of others. In the usual development, the former decisions will tend to decrease, the latter to expand as he grows older. The latter may be emphasized by misfortune in the shape of early illness from disease or accidental injury.

Existence in the world of men also means opportunity, by positive action, to seek satisfactions, whether of comfort, power, wealth, or whatnot. And it is here that the concept of risk, and of probability of gain or loss, enters. Will a certain line of conduct lead to the satisfactions that this particular person desires? A young man decides to study medicine, to forego immediate satisfactions in pursuit of opportunity for scientific study, respect, financial return.

He reasons that he probably will attain these things by investing time and effort in his education. He knows that the results are not certain, that degrees of success vary all the way from flunking out to becoming a famous and highly paid authority, but he "takes the risk." Often he does not reason, but only follows a path that attracts him because of his immediate interest in the subject, or because his family will finance his study, while he would otherwise be on his own.

Another man goes into business. He seeks profits in the economic sense—crudely, a return of greater income than he has expense. But he also seeks power, prestige, and the specific things that his money will buy. As he makes his business decisions he is constantly weighing probabilities, consciously when he adds up the figures and observes statistical trends, unconsciously when he relies on "business judgment." He never *knows* what is going to happen, but he takes the risks involved in conducting his business in the conviction that the probabilities are in his favor.

While we are subject to the uncertainty of occurrence of a multitude of future events, this discussion will deal only with uncertainty that involves a possibility of economic loss.

Here arises, apparently, a certain logical difficulty, since this is an ordered universe in which events take place in accordance with natural laws in which chance can play no part. But the contradiction is only apparent. Occurrences may take place in accordance with fixed laws, but if those laws are unknown to an individual or community or if all the forces at work on the particular subject matter are not known, then to that individual or community the precise outcome cannot be foreknown. Hence uncertainty may exist. An example of risk where the uncertainty is due to incomplete knowledge of natural laws is that due to earthquake; of risk where the uncertainty is due to lack of knowledge of all forces at work, that of destruction of a garage by fire, which may result from employees smoking contrary to orders, spontaneous combustion of oily waste not properly disposed of, or any one of a number of things which one might know would cause a fire if present, but the presence of which cannot be foretold.

It is possible that the outcome may be known to certain persons or communities and not to others. In the present state of civilization, however, with present means of communication, this is not likely to be the case except in a few more or less remote instances. If the precise outcome of an event is foreknown, there is certainty, and whether or not it involves loss, it is not properly termed a "risk." As knowledge of natural laws expands and control over the forces that may enter into a given situation increases, risks tend to be eliminated. For example, when house lighting by electricity was first introduced, fires due to electric current were common, and there was a considerable risk involved; but with increased knowledge of safe practice and insistence

on such safe practice, fires are much less likely to be caused by this hazard. There is still some risk, for occasionally mice or rats or chafing may remove insulation and cause short circuits and fires, but the degree of risk is much less than formerly. This illustration also shows that progress in scientific knowledge may, at least temporarily, increase hazard by introducing a new process into general use before all its dangers are known and proper safeguards worked out.

The most important aspects from which the concept of risk may be studied are (1) its nature, (2) its degree, and (3) its value.

NATURE OF RISKS IN ECONOMIC LIFE

Since insurance is not concerned with all classes of risk, it is well to give consideration first to classification of risks according to their nature.

Pure Risks and Speculative Risks

One useful classification distinguishes between (1) pure risks and (2) speculative risks. In both these classes there is uncertainty as to the outcome of the event under consideration, with usually[3] at least one outcome producing loss; in the case of speculative risks, there is also at least one possible outcome producing profit which could not result from pure risks. As an example of the first class may be cited any new commercial or manufacturing enterprise. Even under the best laid plans there is more or less uncertainty whether the enterprise will succeed or fail. If it succeeds, it will yield a profit. Failure means loss. A simpler example of the principle of speculative risk is the ordinary wager on the toss of a coin or throw of dice. There is uncertainty as to outcome, and for either party a chance of gain and of loss. Possession of any form of destructible property is an example of exposure to pure risk, since its destruction is always possible but not certain, and its destruction results in loss while its preservation does not of itself yield any increase in value or profit.

In other words, the distinction under this classification is between risk that is incurred by the individual or the business concern in the hope of reward and the pure risk that is incidental to other activities or relationships. Risks taken in the hope of reward may result in loss, no change, or gain. Pure risk can result only in loss or no change.

[3] Speculative risk or uncertainty is also present when the person is certain that he cannot lose but does not know how much, if anything, he will win. Unfortunately, most situations do involve at least one possible loss.

Admittedly, the line of demarcation is difficult to draw, but there *is* a distinction. A business, for example, decides to develop a new product for which it hopes to find public acceptance. Money and time are invested in expectation of a return that will justify the investment. The risk that the product will not sell, or that it cannot be produced in accordance with plans, is a business risk, incurred in the hope of satisfactory reward. Risk management is not concerned with this sort of risk.

But in developing the new product and putting it on the market, buildings are erected and machinery is purchased; workmen are employed; automobiles are put on the road; the whole complex of a business operation is set in motion. Aside from the project as a business venture, but incidental to it, is the entrepreneur's risk of loss to his property by fire or other casualty, of becoming liable for payment of workmen's-compensation benefits, of liability for injury caused by the operation of his cars. These are the risks with which risk management is concerned.

Parallel examples may be drawn from individual and family life. A man purchases a yacht and prepares it for competition; he looks forward to winning races, his reward. His investment may turn out to be abortive; the yacht may be inferior to competing craft, or its owner lack the sailing skill necessary to win. He has incurred risk in search of satisfaction and perhaps has had in mind that the market value of a successful craft would be maintained or increased. But none of these items is part of his problem of dealing with risk as such. In this case his problems will be those of loss to the yacht by casualty and of liability for damage it may do.

A family collectively agrees that a certain house will make a satisfactory home. But they find that what seemed eminently suited to their needs has become unsatisfactory. The family has outgrown the house; the father who had a position with a nearby business accepts a better opportunity at an inconvenient distance; other changes make it necessary to sell at a sacrifice and meet the expenses of moving and of equipping a new residence. The risk of these happenings is inherent in family life, but again may be contrasted with the risk of loss to the house by fire or windstorm, of extra expense of living elsewhere while the house is being repaired, of liability for injury to the newsboy who trips over a roller skate left on the walk.

Pure risks also differ from speculative risks in that they are more amenable to the law of large numbers, described in the next chapter. This means that one can more successfully predict the proportion of units that will be lost if they are exposed to a pure risk than if they are subject to a speculative risk. One notable exception to this statement is the speculative risks associated with games of chance, which are highly amenable to this law.

Finally, in a situation involving a speculative risk, society may benefit even though the individual is hurt. For example, the introduction of a socially

beneficial product may cause a firm manufacturing the product it replaces to go bankrupt.[4] In a pure-risk situation society suffers if any individual experiences a loss.

Because insurance is concerned with pure risks, this text will concentrate on the nature and treatment of these risks. Much of what is said, however, can also be applied to speculative risks.

Static Risks and Dynamic Risks

Another classification groups risks according to whether they are (1) static or (2) dynamic. Dynamic risks are associated with changes in human wants, technology, and organizations. Static risks would exist even if the economy and society witnessed no such changes. They are "connected with losses caused by the irregular action of the forces of nature or the mistakes and misdeeds of human beings."[5] Although the overlap is not perfect, pure risks and static risks encompass approximately the same situations. Hence, the two terms are often used interchangeably.

TYPES OF LOSS ASSOCIATED WITH PURE RISKS

The losses associated with pure risks can be classified first according to the nature of the loss. These classes can then be subclassified as to the (1) perils and (2) hazards producing the loss. A peril is the cause of the loss; examples of perils are fires, automobile collisions, and accidents for which the insured is legally liable. A hazard is a condition that creates or increases the chance of loss or the severity of the loss; examples are oily rags, defective brakes, and negligent driving.

Classifying losses in this way is useful because it helps one to identify and measure the types of loss to which one is exposed and because it identifies some potential areas for the application of loss-prevention-and-reduction measures.

In the following brief review of the several types of loss to which mankind is subject, mainly those have been selected that may be covered in whole or in part by insurance. Only the nature of the losses and some of the leading perils involved will be indicated; the reader should be able to supply several hazards for each peril specified.

[4] Wagers always result in some winners and some losers. Other speculative-risk situations may result in all winners or all losers.

[5] A. H. Willett, *The Economic Theory of Risk and Insurance*, pp. 14–23.

Individuals, families, and businesses are subject to the three major types of loss listed below:

1 Destruction, damage, or disappearance of property with resultant loss of income (such as rental income) or extra expenses (additional living expenses while temporarily residing in a motel) caused by:
   - a Fire
   - b Lightning
   - c Windstorm
   - d Water
   - e Earthquake
   - f Glass breakage
   - g Explosion
   - h Riot or civil commotion
   - i Vandalism and malicious mischief
   - j Theft or dishonesty of employees
   - k Fraud
   - l Smoke
   - m Hail
   - n Nuclear incident
   - o Transportation perils
   - p Strikes
   - q Failure of contractors to fulfill contracts
   - r Insolvency of customers or depositories
   - s Other perils

2 Loss of income or property required to defend and settle a claim or pay a judgment or award because of an occurrence for which the person is or may be legally liable under the common law or some special statute

3 Loss of income or extra expenses caused by:
   - a Death
   - b Poor health
   - c Unemployment
   - d Superannuation

The nature of these losses will be explored in more detail in later sections of this book.

MEASUREMENT OF RISK

Three useful measures of risk are (1) the degree of risk, (2) the value of the risk, and (3) the expectation of loss.

Degree of Risk

In dealing with speculative or with pure risk, one finds different degrees of risk, depending on the uncertainty of loss or gain. If it is foreknown that the loss is inevitable and there is no uncertainty even as to the time when it will occur, then clearly there is no risk however great may be the loss. Cases involving this type of certainty are rare except where property is destroyed in promoting some other cause of gain, as when coal is burned to produce steam in a boiler. A case is occasionally found, however, where the certain loss is not brought about as a means of gain. For example, a number of years ago a portion of the city of Honolulu was burned by the federal authorities because of infection with bubonic plague. The loss of the buildings was certain, and there was no risk in respect of those buildings.[6] There was risk of loss on surrounding buildings, because of the uncertainty lest the fire get beyond control and destroy them, a risk that actually resulted in heavy loss for the insurance companies covering them, for the fire did get beyond control.[7] If, on the other hand, it is certain that a particular loss cannot occur, for example, the destruction by fire of a masonry dam, then also there is no risk.

Thus there is a distinction between risk and probability of loss. The probability (chance of loss) may vary from zero (certainty of no loss) to 1 (certainty of loss), but at each extreme there is no risk because there is no uncertainty. The greatest uncertainty exists when the probabilities are evenly balanced, for example, in a wager that a coin which is to be tossed will fall heads. The risk diminishes in passing from this degree of probability to either extreme. For example, as probability indicates that 6, 7, 8, or 9 houses out of 10 will be lost by fire, the uncertainty that a particular house will burn becomes less; similarly, as the probability becomes less than 5 out of 10, say, 4, 3, 2, 1.

In most pure risks met in economic life, the probability of loss is so small that the degree of risk and the probability of loss are approximately equal. Because of the expense involved, the insurance business cannot effectively deal with risks approaching the maximum uncertainty—those in which the probability of loss approaches 50 per cent.

Suppose that, in the case of a certain commodity, it is probable that

[6] It may be alleged that even here the loss was brought about as a means of gain, namely, the removal of the plague danger, or that there was no real loss since the infection had already destroyed the value of the premises. These contentions may be admitted as sound, but the point is not essential to the argument. The case is merely cited as an example of the absence of risk associated with total loss. Such cases are rare except when the destruction is a part of a large constructive process.

[7] About thirty years later Congress by special act provided for reimbursement to the companies.

$250,000 will be lost by a peril such as fire, out of a total value of $500,000, and that the expenses of conducting the insurance business are equal to the losses paid. It would be necessary for the insurer to collect the full value of the commodity in order to break even. Dealing in such a commodity, or in any commodity whose situation approached this condition, would be entirely impractical.

Value of Risk

Risk may also be considered in relation to the amount of loss that may occur. From the point of view both of the individual and of society, the importance or *value* of any particular risk hinges largely on the amount of *possible* loss. It is, however, not the absolute size of a possible loss that is of controlling importance, but the size in relation to the available margin for contingencies. If the individual exposed to a risk is of low economic strength with but a narrow margin of property beyond that required for adequate subsistence, even a very small loss may be more than he can stand without evident suffering. On the other hand, a man whose resources run into the millions might suffer little hardship though a loss ran to several thousand dollars. Again, the pressure of loss depends upon its incidence. Even a man of large wealth might be put to some embarrassment to meet a sudden immediate need amounting to a relatively small sum. But, though the cause be sudden and unforeseen, if the liquidation can be spread over a period of time, often no great difficulty will be involved in meeting a large loss.

Expectation of Loss

A very useful concept—one that, as will be apparent later, lies at the foundation of insurance—is that of *expectation of loss*, which is the product of the amount at stake and the probability of loss.[8] If, for example, $10 is wagered on the toss of a coin, the expectation of loss is $5, since the probability of loss is one-half and the amount at stake is $10. Since by "probablility of loss" is meant the proportion of total ventures which, according to statistical evidence or *a priori* reasoning, must result in loss in the long run (the definition ordinarily used in discussions of the mathematical theory of probabilities),[9] it is

[8] If there are several possible outcomes, the expected value is obtained by multiplying each possible outcome by its probability and summing the results. For example, if the possible outcomes are no loss, a $5 loss, or a $10 loss with respective probabilities of ½, ¼, and ¼, the expected loss is $0(½) + $5(¼) + $10(¼) = $3.75.

[9] For a discussion of the logical foundation for this definition see J. M. Keynes, "A Treatise on Probability."

evident that, *management expense or profit for risk bearing in the short run not being considered,* the expectation of loss is the amount one would expect to pay another to take his place by becoming exposed to the risk. The latter would, if he entered into enough such arrangements, suffer no net loss in the long run.

This is the principle underlying the conduct of many gambling enterprises. If the proprietor of a gambling establishment had a sufficient fund to cover a temporary adverse run and, for the time, did not have to consider expenses, he could provide a perfectly fair deck of cards, charge a patron 25 cents for the privilege of cutting them, agree to pay $1 if a spade (or any other agreed suit) were cut, and come out even in the long run. Were he to charge a few cents more, he would be able to pay expenses and have a margin of profit. On the average he must lose, i.e., pay, once in four times because one-fourth of the cards are of each suit, and the probability of loss to him is one-fourth. The expected loss, i.e., the net price he must charge, is the product of this chance by the prize. To the expected loss he must add a margin for his expense and profit.[10]

RISK AN ECONOMIC BURDEN

It has been indicated that, to the man living close to the poverty line, a loss of a small amount may be a catastrophe. Even to the man of wealth, any substantial loss may be a sufficient blow to call for some readjustment of his affairs. If, for example, it were not possible for one to be reimbursed by insurance for loss by fire, shipwreck, or similar occurrences and if one had no other means (surplus), one might face ruin or at best a serious reduction in economic status. A classical example of a man of position so brought low is Antonio in the "Merchant of Venice." This would be the result, whether the risk were a pure risk and unavoidable as a risk, such as the loss of a home by fire caused by lightning or earthquake, or one undertaken as part of a speculative venture in the hope of avoiding loss and of obtaining a profit. Were such losses to happen to any substantial part of a community there would be a heavy social loss, a loss greater than the value of the property destroyed, by reason of the consequent general reduction of community standards.

Prudent men do not willingly expose themselves to such losses but, if they cannot rid themselves of the risk, they accumulate a surplus or sinking fund to meet the contingency. The plain common sense of such a policy is expressed in the old adage, "Put something aside for a rainy day." Although thrift and saving are generally useful to society as a means of accumulating

[10] This principle of probability will be discussed further in a later chapter.

capital, such individual sinking funds are not often employed in as useful undertakings as are funds not impressed with this quasi-trust character. Society loses to the extent of the excess of the potential over the actual service value of such reserved funds. Further, the reserved funds could not safely be accumulated gradually, for there would be no assurance that the loss might not occur before sufficient funds had been built up to meet it, and their purpose thereby be defeated. Rather, the funds must be available step by step as destructible property is acquired. Because of the difficulty of making such provision, men are deterred from entering into ventures that expose them to risks or, if they do venture, do so only on terms involving large opportunities for profit. This inability to secure certain services at a reasonable cost is probably the heaviest social burden imposed by risk.[11]

Thus society suffers from the existence of risk, either through exposure to (1) the chance of reduction in general well-being, (2) unproductive use of capital, or (3) failure to secure desired advantages.

Risk and Credit

Important as the burden of risk upon society would be under the simplest conditions, its weight is enhanced in a society living under a highly organized credit economy. The lender of capital desires a return in the form of interest on his capital, but, were he to lose it in seeking that return, his condition would be worse than if he had allowed it to remain idle. Consequently, he will lend it for use only where the major risks to which it is exposed can be avoided. This is true of prudent investors, and particularly true of bankers and others charged with the investment of funds for the safety of which they are responsible. For example, bills of exchange in overseas trade are readily discounted when accompanied by proper documents, *including evidence of adequate insurance*, but not otherwise. Again, banks require, in addition to a mortgage on real property, adequate insurance with a mortgagee clause attached giving them the first benefit of the insurance in all cases where insurable property is part of the security for their loan.

[11] As an example, reference may be made to the allegation that reluctance on the part of insurers to furnish aviation insurance retarded the development of commercial aviation in the United States, because the risks were too great for individual entrepreneurs. The insurers were reluctant because of the large value of the risk involved which, in turn, resulted from the large amounts at stake and the high degree of uncertainty of loss. Since then, however, the risk having been greatly reduced, insurance facilities adequate to development of commercial aviation have been made available. A more recent example was the reluctance of insurers to provide insurance required for the peacetime development of nuclear energy. To provide insurance for the operators of atomic reactors, insurers created special underwriting associations and the government limited the liability of the operators.

It is true that speculatively inclined investors daily put their funds into enterprises in which the risk is great, sometimes knowingly, sometimes unwittingly. But the action of the unwitting can hardly be taken as typical. Where a risk is undertaken knowingly, there is a prospect of gain which is deemed by the speculator to exceed the prospect of loss. This may take the form of a higher rate of current return, a part of which is compensation for risk.

QUESTIONS

1 Distinguish between risk and chance of loss.
2 For what reasons may consciousness of uncertainty differ from uncertainty itself?
3 Cite five illustrations of (*a*) a speculative risk and (*b*) a pure risk.
4 Outline briefly the types of loss faced by a typical manufacturing concern.
5 If a family has a building valued at $10,000, the probability of loss is $\frac{1}{10}$, and all losses are total, how would you determine the expected loss? the degree of risk? the value of the risk?
6 Would it be desirable to eliminate all risks from economic life? Why?

2
RISK AND STATISTICS

Risk is all-pervasive. Everything one does, every situation in which one finds himself, involves personal or family risk. Every activity of a business, every business situation, involves risk. Although insurance is concerned only with pure risks, there are two reasons why it is desirable to consider briefly a broader concept of risk before beginning a much more detailed study of pure risk and its treatment. First, one should be constantly aware of the fact that scholars and practitioners in all fields are constantly studying risk. The study of pure risk is only part of a much larger whole. Second, many of the concepts developed in other areas are extremely useful in the study of pure risks, and vice versa.

Because of the pervasiveness of risk, examples of risk situations could be presented without limit from every phase of life. However, in order not to depart too long from the major concern of this text, discussion will be limited to the role of risk in four closely related fields—statistics, economic theory, psychology, and business administration. Even this more limited scope will permit only a sampling of the risk theory developed and developing in each of these areas. The relationship between risk and statistics will be sampled in this chapter. Chapter 3 will discuss more briefly the other three fields.

Statistics "refers to the body of techniques, or methodology, that has been developed for the collection, presentation, and analysis of quantitative data, and for the use of such data."[1] In developing methods for collecting and analyzing quantitative data, statisticians have made numerous contributions to risk theory. Probability itself is a statistical concept, and modern statisticians devote most of their efforts to (1) estimating population parameters (such as the average value of a certain characteristic) on the basis of a small sample from that population or (2) decision making under conditions of risk or uncertainty. Consequently any person seriously interested in the study of

[1] John Neter and William Wasserman, "Fundamental Statistics for Business and Economics," p. 1.

risk should acquire a basic understanding of statistical methodology. A few of the more fundamental concepts will be considered here.

Probability

The probability of a particular outcome has already (p. 11) been interpreted as the proportion of total ventures which, according to statistical evidence or *a priori* reasoning, would result in a particular outcome in the long run under a constant cause system. If the probability is 0, there will be no loss; if the probability is 1, there will be a loss.

Probability can be determined by *a priori* reasoning only under certain special circumstances. There must be a number of equally likely outcomes, a certain fraction of which represent the particular outcome whose probability is being determined. For example, the probability of obtaining a head when a "fair" coin is tossed is ½ because (1) there are two equally likely outcomes—a head or a tail[2]—and (2) one of these outcomes is a head. The probability of drawing a spade from a deck of cards is ¼ because (1) there are 52 equally likely outcomes and (2) 13 of these outcomes are spades. The probability of drawing a ten of diamonds is $\frac{1}{52}$, a ten of diamonds or a ten of hearts $\frac{1}{26}$, and an ace of any suit $\frac{1}{13}$.

In most cases probability cannot be determined in this way because the problem cannot be analyzed in terms of equally likely outcomes. For example, one cannot determine *a priori* the probability that a light bulb coming off a production line will be defective, that the number of phone calls a day through a specified exchange will exceed 100, or that a person, aged 35, will die in the coming year. In cases such as these, the probability can be estimated by computing the proportion of times the outcome in question occurs in a long series of repeated observations. For example, the statistician can compute the proportion of defective light bulbs among a large number of tested bulbs, the proportion of days over a long period of time in which the number of phone calls at the exchange exceeded 100, and the proportion of deaths in a large group of men, all of whom were aged 35 at the beginning of the year. Probability can be measured in this way because, according to the law of large numbers described at the close of this chapter, as the number of observations increases, the proportion of times a certain outcome occurs tends to approach the underlying probability.

In order to apply this relative-frequency definition of probability, sometimes called *objective* probability,[3] the event must be repeatable. Otherwise one cannot speak about the proportion of outcomes in the long run. Conse-

[2] It is assumed that the coin will not remain standing on its edge.
[3] Neter and Wasserman, *op. cit.*, pp. 193–195.

quently, under this interpretation of probability, it is improper to talk about the probability that a certain candidate will win an election or that a specific individual, aged 35, will die during the next year, because these are not repeatable events. The outcomes will or will not occur. It is reasonable, however, to talk about the probability that a person, aged 35, will die during the next year if we mean that *about* this proportion of persons will die out of a large number of persons aged 35.

Probability can also be interpreted as a degree of belief. Under this interpretation, known as *subjective* probability, it *is* reasonable to apply the concept to unique events. This probability is called subjective probability because the value depends upon the information available to the person making the estimate, his ability to analyze this information, his biases, and so on. In connection with most repeatable events, an objective probability exists but decision makers must often use a subjective estimate of that objective probability. Some statisticians believe that the concept of subjective probability has limited usefulness.

Mutually Exclusive Outcomes

Two outcomes are mutually exclusive if they cannot occur together. For example, a product cannot be both defective and nondefective; a person, aged 35, cannot both die in the next year and live to the end of that year; collision damage to an automobile in the next year cannot be at the same time nothing, $50, $100, $1,000, and $3,000. Under an objective-probability theorem, the probability that the actual outcome will be one of two or more mutually exclusive outcomes is equal to the sum of the probabilities of the separate outcomes. In the automobile-collision example cited above, the probability that the collision damage to the car during the coming year will be $1,000 or $5,000 is equal to the probability that the loss will be $1,000 plus the probability that the loss will be $5,000.

The sum of the probabilities of all possible mutual events must be unity, because one of these events is certain to occur. Consequently, the probability that a product will either be defective or not defective must be unity. The same is true of the probability that a person, aged 35, will either live or die or the probability that the collision damage in the above example will be either 0 or one of the values noted. One important use of this theorem in risk management is that if one knows the probability that there will be no loss, one can determine the probability of a loss of some amount (various amounts being possible) by subtracting from 1 the probability of no loss.

Psychologists have discovered that the theorems of objective probability may not apply to subjective probabilities, including subjective estimates of

objective probability. Further discussion of this point will be deferred until the next chapter.

Compound Outcomes

A compound outcome is the joint occurrence of two separate outcomes. The method for determining the probability of a compound outcome depends upon whether the separate outcomes are independent. Two outcomes are independent of one another if the occurrence of one outcome does not affect the probability that the other will occur. For example, the probability that an automobile in New York City will suffer a collision loss is not affected by a collision loss to an automobile located in California. Consequently, the two outcomes are independent. On the other hand, the probability that a building will burn is increased if a nearby building is already burning. Consequently, a loss to one of these buildings is not independent of a loss to the other.

If the two or more outcomes are independent, an objective-probability theorem states that the probability of the compound event is the product of the probabilities of the independent events. For example, if the probability of a collision loss to the automobile in New York is $\frac{1}{10}$ and the probability that the car in California will suffer a loss is $\frac{1}{5}$, the probability that both cars will suffer a loss is $(\frac{1}{10})(\frac{1}{5}) = \frac{1}{50}$.[4]

The probability that two men, aged 35 and 50, respectively, and independently exposed to death, will die in the next year is equal to the product of the probabilities of death for each man separately, say, (2 ′ 1,000)(8 ′ 1,000) = 16/1,000,000.

If the outcomes are not independent, the probability of a compound outcome involving two separate outcomes is determined by multiplying the probability of one of the two outcomes by the (conditional) probability of the second outcome, *given that the first outcome has occurred.* For example, if the probability of a fire loss for each of two buildings is $\frac{1}{50}$, the probability that both buildings will suffer a fire loss, assuming independence, is $(\frac{1}{50})(\frac{1}{50}) = \frac{1}{2500}$. However, if the probability of a fire loss to one building increases to $\frac{1}{2}$ if the other building is already on fire, the probability that both buildings will burn is $(\frac{1}{50})(\frac{1}{2}) = \frac{1}{100}$. A somewhat different application of this concept occurs in life insurance. The probability that a person, aged 35, will die when he is

[4] The other three possibilities and their probabilities are as follows:

Loss in New York, not in California: $(\frac{1}{10})\ (1 - \frac{1}{5}) = \frac{4}{50}$.
No loss in New York, loss in California: $(1 - \frac{1}{10})\ (\frac{1}{5}) = \frac{9}{50}$.
No loss in either location: $(1 - \frac{1}{10})\ (1 - \frac{1}{5}) = \frac{36}{50}$.

The sum of the probabilities for the four mutually exclusive probabilities should and does equal unity.

aged 50 is equal to the probability that he will live to be 50 multiplied by the probability that, having lived to age 50, he will die during the following year. If the probability that a person, aged 35, will live to age 50 is 950/1,000 and the probability that a person, aged 50, will die in the next year is 8/1,000, the desired product is

$$(950/1{,}000)(8/1{,}000) = 7{,}600/1{,}000{,}000.$$

Probability Distributions

A probability distribution specifies each of the basic mutually exclusive outcomes and its respective probability. The distribution may be presented in tabular or graphic form. For example, a business may face the probability distribution in Table 2–1 with respect to losses on shipments to customers each year. With information such as this, it is possible to compute the probability of any outcome or combination of outcomes. For example, the probability of eight or more losses is (0.0009) + (0.0002) + (0.0001) = 0.0012.

Table 2–1 HYPOTHETICAL PROBABILITY DISTRIBUTION FOR NUMBER OF LOSSES

Number of losses	Probability of loss
0	0.1353
1	0.2707
2	0.2707
3	0.1804
4	0.0902
5	0.0361
6	0.0120
7	0.0034
8	0.0009
9	0.0002
10 or more	0.0001
	1.0000

Statisticians have determined that a limited number of distributions with certain useful characteristics provide good approximations to the actual probability distribution in a wide variety of situations.[5] One particularly useful distribution in risk-management and insurance problems is the Poisson distribution. According to this distribution, if m represents the average number

[5] Neter and Wasserman, *op. cit.*, pp. 213–226.

of losses per period in the long run, the probability that the number of losses in a specific period will be r is determined as follows:

$$\text{Probability of } r \text{ losses} = \frac{(m)^r e^{-m}}{r!}$$

Since e^{-2} is approximately 0.3679, if the average number of losses is 2, the probability that there will be three losses in a specific period is

$$\frac{(2)^3 e^{-2}}{3!} = \frac{8(0.3679)(0.3679)}{3 \times 2 \times 1} = 0.1804.$$

Probabilities for 0 losses, 1 loss, 2 losses, and so on, are contained in Table 2–1, which assumes that a Poisson distribution applies and that the business will experience two losses a year on the average. The Poisson distribution is appropriate when there are a large number of units exposed independently to loss and the probability of loss to any unit is small (under $\frac{1}{10}$, say). In Table 2–1 it is assumed that the business makes many shipments each year and that the probability of loss to any single shipment is small. In other instances a business or a family may have only a few cars or buildings exposed to loss but each unit can suffer several losses a year. Each day (or hour) the car or building is exposed represents an independent exposure for each car or building, with the result that, instead of having a few units exposed to loss, the business or family has many car-days or building-days during which each is independently exposed to a small probability of loss. Consequently, the Poisson distribution is a satisfactory approximation in many risk-management and insurance problems because repeat losses are usually possible and the probability of loss is generally small.

Expected Value

One important characteristic of a probability distribution is its expected value or the average value in the long run. This concept has already been introduced briefly in Chapter 1. The expected value is obtained by multiplying each outcome by its respective probability (which measures the proportion of times this outcome would occur in the long run) and summing the resulting products. For example, if in Table 2–1 the class of 10 or more assumed to be 10, the expected number of losses for that distribution is 0(0.1353) + 1(0.2707) + 2(0.2707) + 3(0.1804) + 4(0.0902) + 5(0.0361) + 6(0.0120) + 7(0.0034) + 8(0.0009) + 9(0.0002) + 10(0.0001), or slightly more than 2.0. If rounding errors could be avoided and the table had provided more detailed information concerning 10 or more losses, the expected number of losses would be exactly 2.0, because this was the assumption made in calculating the Poisson probabilities.

In the fairly common case where there are n objects each exposed to at most one loss with the probability of loss to a particular object being p, the binomial distribution applies[6] and the expected number of losses is np. For example, if there are 25 objects exposed to at most one loss per year and $p = 1/10$, there will be, on the average, one loss every 2 years.

The expected total dollar losses per year are of special interest to an insurer because its premium must cover these expected losses plus its expenses and some margin for profit, contingencies, or dividends. A person considering the purchase of insurance will want to compare his estimate of the expected dollar losses with the premium quoted by the insurer. Unless his estimate is much greater than that of the insurer, the insured must be willing to pay some amount in addition to his expected losses before he will decide to purchase the insurance. He may be willing to do this because of an aversion to risk which depends upon his estimates of the degree of risk, the magnitude of the potential losses, his economic status, and his own personality. The effect of these factors upon his decision will be considered in more detail in the discussion of the relationships between risk, economics, and psychology in the next chapter.

Standard Deviation

Another important characteristic of a probability distribution is its variation, dispersion, or scattering. The most popular measure of this variation is the standard deviation, which is determined as follows:

1 From each outcome subtract the expected value.
2 Square each of the resulting differences.
3 Multiply each square by the probability associated with the outcome for which the squared difference was computed.
4 Sum the resulting products.
5 Determine the square root of the sum.

The standard deviation, therefore, depends upon the distances between the various outcomes and the expected value. If the values are concentrated about the expected value, the standard deviation will be small. If the values are widely dispersed, the standard deviation will be large.

If the probability distribution is a Poisson distribution, it is not necessary

[6] Probability of r losses $= \dfrac{n!}{r!(n-r)!} p^r(1-p)^{n-r}$ where $n! = n(n-1)(n-2) \ldots 1$ and $0! = 1$. For example, $4! = 4 \times 3 \times 2 \times 1$. If n is large and p is small, the Poisson distribution is a reasonable approximation to this distribution. If n is large and p is not too small (say $1/10$ or more), the normal distribution described later in this chapter can be used as an approximation.

to compute the standard deviation in this way because it is always equal to the square root of the mean. The binomial distribution has a standard deviation equal to $\sqrt{np(1-p)}$. Thus if $n = 25$ and $p = 1/50$, the standard deviation is $\sqrt{25 \times 1/50 \times 49/50} = 7/10$.

The formula for the standard deviation of a binomial distribution shows that the standard deviation increases as the number of exposure units increases, but not proportionately. For example, increasing the number of exposure units from, say 4 to 16, a fourfold increase, doubles the standard deviation. Relative to the mean, which *does* increase proportionately, or to the number of exposure units, the standard deviation decreases. It is for this reason that it is generally stated that risk decreases as the number of exposure units increases. The proportion of losses to be experienced becomes more predictable; uncertainty decreases. The law of large numbers described later also depends upon this fact.

One reason the standard deviation is such a useful tool is that, according to the Chebyshev inequality, under any distribution the probability that the outcomes will fall k standard deviations from the mean is $1/k^2$ or less. To illustrate, if the expected loss is \$100 and the standard deviation is \$40, the probability that the actual losses will differ from \$100 by \$80 (2 times \$40) or more is *no more* than $1/(2)^2$ or $1/4$.

Normal Distribution

If the probability distribution is a normal distribution, the standard deviation is an even more useful concept. The normal distribution is the familiar bell-shaped distribution that has been used to describe such phenomena as collar sizes, grades in a college course, and the tensile strength of iron bars. In risk-management and insurance problems, a common use of the normal distribution is as an approximation to the binomial distribution when the number of exposure units is large and p is not too small (say $1/10$ or more). For example, if $n = 100$ and $p = 1/10$, a normal distribution provides a reasonable approximation to a binomial distribution with an expected loss of $np = 100(1/10)$, or 10, and a standard deviation of $\sqrt{np(1-p)} = \sqrt{100(1/10)(9/10)}$, or 3.

One reason the normal distribution is so attractive is that with this distribution it is a relatively simple matter to determine the probability that the outcomes will fall within a given range. To determine this probability, one must first express the difference between each of the end points of the range and the expected value as a multiple of the standard deviation. With the aid of tables found in introductory statistics textbooks, the next step is to determine the probability that the actual outcome will fall between the mean and each of the end points expressed in this way. For example, if one end point is one

standard deviation above (or below) the mean, the probability is about 34 per cent that the loss value will be between the mean and this end point. If the end point were instead two standard deviations above (or below) the mean, the corresponding probability would be about 47.5 per cent. If the two end points of the range lie on opposite sides of the mean, the probability of the actual outcome falling in the range is obtained by adding the probability that the loss will fall between the mean and the lower limit to the probability that the loss will fall between the mean and the upper limit. To illustrate, if the mean is 10 and the standard deviation is 3, as assumed above, the probability that the number of losses will be between 4 and 16 is 47.5% + 47.5%, or 95 per cent. If the two end points lie on the same side of the mean, the smaller probability is subtracted from the larger probability. For example, using the above assumptions concerning the mean and the standard deviation, the probability that the number of losses will be between 13 and 16 is 47.5% − 34%, or 13.5 per cent. Of particular interest is the probability that the losses will exceed a given value in excess of the mean. In this instance the upper limit of the range is the highest possible value, the lower limit being the specified value. Because the normal curve is symmetrical, the probability that the losses will exceed the mean is 50 per cent. Hence the probability that the number of losses will exceed 16 in the above illustration is about 50% − 47.5%, or 2.5 per cent.

Law of Large Numbers

One of the most useful and famous "laws" of mathematical probability is the *law of large numbers.* Because of its extreme importance to the study of risk and insurance and the support it provides for the relative-frequency interpretation of probability, this law will be explained in some detail.

The list of perils to which mankind is subject is long and formidable. Every individual is subject to many risks arising from these perils each day from the cradle to the grave. Although this point has been made in many earlier sections of this text, it is so important that it merits repetition. Were there no qualifying factors, one would indeed be justified in looking upon the world and its affairs with a pessimistic eye. But the universe is governed by natural laws; and if all conditions and forces operating could be foreknown, results could be foretold with assurance. Loss would still remain, but uncertainty would disappear. In a world so ordered, it would seem natural that the unknown and unobserved forces would tend to balance, if enough cases could be observed, and that the uncertainty or risk present in the individual instance would disappear in the mass. This tendency of mass phenomena toward regularity has been demonstrated by experiment and has been formulated in the "law of large numbers."

The term *law of large numbers* was used by the French mathematician, Poisson, in an article on "Researches on the Probability of Judgments"[7] and is defined in terms of probabilities.

Poisson's law may be stated:[8] "If an event be tried repeatedly with probabilities $p_1 p_2 \ldots$ for success which may be constant, or may vary with each trial, then if the number of trials increase indefinitely, the probability that the difference between the average probability and the observed ratio of success will differ by less than any assigned quantity approaches 1 as a limit."

This exact statement of the law may be confusing to the nonmathematical student. In more popular but less exact language it means that as the number of trials increases, the proportion of results approaches the underlying probability. For example, if a single card is drawn from a well-shuffled deck, it may be any one of 52; but, since one-fourth of the cards are spades, the probability of drawing a spade is one-fourth. This does not mean that, if only four cards are drawn, one, and only one, will be a spade. It can be shown that there is a strong probability against this exact result. Nor does it mean that, if 40 are drawn, exactly 10 will be spades. It does mean that, as the number of trials is increased, the ratio of drawings of spades to the total drawings tends to become one-fourth, though the actual departure may be great. Its operation is not subject to exact proof, as is that of the law of gravitation, except under purely mechanical and artificial conditions similar to those used in defining probability, and it should be borne clearly in mind that it is not put forward as a universal law.[9] The important point is that, where it has been found by experiment to hold, the law of large numbers may be used to reduce, or even eliminate, risk. It can be used in two ways: (1) to estimate the underlying probability when this cannot be determined by *a priori* reasoning after observing what has happened in the past in a large number of trials and (2) to increase the likelihood that this proportion will be experienced in the future by conducting a large number of trials.

The operation of the law of large numbers has already been illustrated by drawings from a deck of cards. It can also be demonstrated by observing that the proportion of heads tends to approach ½ as the number of times a coin is tossed increases and that the proportion of aces tends to approach ⅙ as the number of times a die is thrown increases. Stability in such phenomena, however, has little practical value except to the gambler. But if the same tendency is present among pure risks, a way can be found to improve the situation by transferring the several risks from the individual to a professional

[7] *Comptes rendus de l'Academie des Sciences*, vol. 1, 1835, p. 473, especially p. 478.

[8] Quoted by J. L. Coolidge, "Mathematical Probability," p. 65.

[9] The proof employs the Chebyshev inequality plus the fact that the standard deviation of the binomial probability distribution applicable to the *proportion* of losses (not the number of losses) is $\sqrt{p(1-p)/n}$, which decreases as n increases.

insurer, which, having a very large number of instances of each, ought to experience such reasonable stability in loss as practically to eliminate the uncertainty.

Such regularity *is* found in practical affairs, although events do not recur with the strict regularity of games of chance and mechanical devices. There is also evident in many cases steady change (*secular trend*) and sometimes a seasonal variation within the year. But seasonal variations tend to operate in opposite directions and to counterbalance each other, as do the variations due to the business cycle. Slower long-time changes can be observed, but predictions of their direction and extent are themselves hazardous. With due allowance for these changes, the law is found to operate with sufficient accuracy for practical use. Mortality tables used in life insurance, constructed at different times and places, show close resemblance in their general results. So do loss records in many other lines of insurance.

Accumulated data evidencing the operation of the law often show sudden and pronounced variations caused by extraordinary events. Such were the San Francisco conflagration of 1906, the influenza epidemic of 1918–1919, and the Second World War.

The principle of mass stability cannot be assumed always to be *practically* applicable; in any new case, its applicability must be tested before it can be relied upon. Only in the case of those risks to which it is found to apply with reasonable approximation is it possible to conduct a sound insurance business that can adequately eliminate or reduce risk. In view of the ordered character of the universe, the law probably does apply to all physical phenomena, but some are of such infrequent occurrence that observations over long periods would be necessary to establish it, too long for practical use. For example, earthquakes seem to occur most irregularly. Yet it seems likely that, observed over a long period, regularity would be found.

There are factors tending to produce long-time changes in degree of risk. The development of knowledge of processes and conditions tends to eliminate uncertainty, even though loss may not be decreased. Generally, however, increased knowledge will be accompanied by greater precautions and safeguards, and losses also will be reduced.

Changes in economic conditions have an important bearing on risks, because of their influence on the volition of those ordinarily subject to risk. The losses of fire-insurance companies increase when business failures increase. The explanation may be partly a tendency to economy which has reduced the safeguards usually present against accidental fires. But all too often the will to protection has not been present, if, indeed, the policyholder in business difficulties has not yielded to the temptation to try to realize on "frozen inventories" by "selling them to the underwriters," as the occurrence of convenient, though supposedly accidental, fires has sometimes suggested. Hazard due to volition of the insured is known among insurance men as "moral

hazard." This risk has not been found to be stable, and for both this and more obvious reasons of public policy, is uninsurable on any terms.[10] In a slightly different category is the absence of a will to safeguard, which may be included under "moral hazard" but is sometimes distinguished as "morale hazard."[11] Such absence of intent to protect does not prevent the operation of the law of large numbers but does tend to increase the probability of loss, making it higher in the individual case than the average of its class. This tends to make underwriters reluctant to take risks where its presence is detected. The existence of insurance tends to create a certain degree of the latter type of hazard by making the insured less concerned with the preservation of his property.[12]

QUESTIONS

1 The probability that an automobile will be involved in a collision is $\frac{1}{50}$. What does this mean?

2 Assume that a business has warehouses in Omaha, Dallas, and Buffalo. The probability that the warehouse in Omaha will be damaged by windstorm is $\frac{1}{10}$, in Dallas $\frac{1}{20}$, and in Buffalo $\frac{1}{10}$. What is the probability that:
   - **a** The warehouse in Omaha will not be damaged? ($\frac{9}{10}$)
   - **b** The warehouses in Omaha and Buffalo will be damaged? ($\frac{1}{100}$)
   - **c** All three warehouses will be damaged? (1/2,000)
   - **d** none of the warehouses will be damaged? (1,539/2,000)

3 A business with 50 employees experiences about four workmen's-compensation claims per year. Employees can incur several injuries in the same year. How would you compute the probability that the business will experience more than four losses next year?

4 A professional association has 100 members exposed to death. For simplicity assume that the probability of death for each member is $\frac{2}{10}$.
   - **a** What is the expected number of deaths? (20)
   - **b** What is the standard deviation of the probability distribution? (4)
   - **c** What is the probability that the number of deaths will exceed 28? (About 2.5%)

5 What difficulties must insurers and self-insurers recognize in the application of the law of large numbers to their special problems?

[10] Insurers often find that they must pay losses due to moral hazard in risks they have assumed, but this statement reflects the views of skilled underwriters passing upon risks in which any considerable degree of moral hazard is indicated.

[11] The recent tendency to observe this distinction is to be commended as leading to clearer analysis.

[12] Although the definition of insurance has been reserved for a later chapter, it seems reasonable in view of the widespread practice of insurance to assume that the reference to insurance in this chapter will not cause difficulty. Some of the observations may profitably be reread in connection with Chapter 5.

3

RISK AND ECONOMICS, PSYCHOLOGY, AND BUSINESS ADMINISTRATION

The relationship of risk and risk theory to statistics was discussed in the preceding chapter. The role of risk and risk theory in economics, psychology, and business administration will now be explored.

RISK AND ECONOMICS

Economics has been defined as "the social science concerned with the problem of using or administering scarce resources (the means of producing) so as to attain the greatest or maximum fulfillment of society's unlimited wants (the goal of producing)."[1] Microeconomics deals with specific economic units such as firms and households in great detail. Macroeconomics deals with the total economy or with collections of specific economic units such as government, households, or businesses.[2]

Both microeconomics and macroeconomics are vitally concerned with the study of risk. Some ways in which risk is an economic burden to society have been discussed in Chapter 1. The examples presented below explore the economic effects of risk in greater detail.

Microeconomics and Risk

One of the major subjects of microeconomics is price and output determination by a firm under varying degrees of competition. Other important topics are the pricing and employment of resources such as labor, land, and capital and the role of profits in our economy. The role of risk in these economic

[1] Campbell R. McConnell, "Economics," p. 26.
[2] *Ibid.*, p. 17.

analyses will be evident from the brief elementary discussion of these three subjects presented below. Many additional topics could be considered, but only one more subject will be discussed in this chapter—the expected utility model developed by economists to explain decision making under uncertainty.

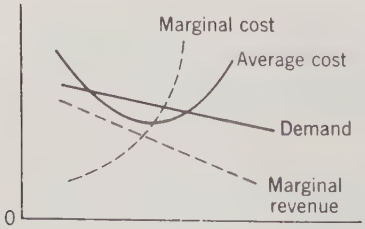
Price and Output Determination. In most elementary discussions of price and output determination, a firm is considered to have as its primary objective the maximization of dollar profits. The firm is usually assumed to produce only one product, for which it wishes to determine that combination of price and output that will maximize this profit. Various degrees of competition can be assumed, but the discussion here will be limited to monopolistic competition and oligopoly, because these two states, although they lack many characteristics of the real world, are more descriptive of the situation in many industries than the two extremes of pure competition and monopoly.

Under monopolistic competition there are a large number of firms, each of which produces a product that differs from its competitor's similar product in some real or imagined (e.g., as a result of advertising) way. The effect of one firm's actions upon each of its numerous competitors is so small that these competitors will probably not react to any price or output changes initiated by that firm. However, none of the firms act collusively to set prices or output. Retail stores in a major city operate under conditions approximating these assumptions, although the leading retail stores may justifiably be considerably concerned about the reactions of their major competitors.

In the short run, according to the usual model, a monopolistically competitive firm should establish its price and output at the point where, as indicated in Chart 3–1, its marginal revenue and marginal cost curves intersect. The reasoning underlying this decision is explained below.

The quantity of its output that the firm can sell at each price is indicated by its *demand* curve. The firm's *marginal revenue* curve is obtained by subtracting from the total revenue (output times price) for a given output the

Chart 3–1 Cost and Demand Curves for a Monopolistically Competitive Firm



total revenue for a given output of one less unit at (in the usual case) a slightly higher price; in other words, the marginal revenue is the additional revenue resulting from the sale of the last unit, recognizing that in order to sell more units the firm must lower its price per unit on all units. The *average cost* curve shows the total costs (fixed costs independent of the volume of output plus the costs that vary with the output) divided by the various levels of output. The *marginal cost* curve shows the additional costs that are incurred by producing one more unit; it can be obtained by subtracting from the total costs for a given level of output the total costs for an output of one less unit.

A firm will maximize its profit if it increases its production up to the point where the additional revenue it obtains from selling one more unit equals the additional costs it incurs in selling that unit. Below that point each additional unit produces more revenue than it costs; above that point each additional unit produces less revenue than it costs.

Risk affects this decision in various ways. First, no firm knows exactly the quantity of its product that it can sell at various prices. Indeed, many firms have at best a crude estimate of their demand function. Their costs are also subject to uncertainties. For example, prices of labor and materials may rise, the production and marketing processes may operate at varying degrees of efficiency, or losses associated with pure risks (e.g., fire losses, automobile-liability suits, or the death of a key engineer) may cause costs to vary from those estimated by the firm. Even if these uncertainties did not exist, cost accountants would be among the first to emphasize the practical difficulties in determining costs, particularly if the firm produces more than one product. Shifts in the demand curve or the cost curve can change significantly the price and output determination. The firm must base its decisions upon estimated demand and cost curves that may differ considerably from reality.

In the long run even more uncertainties are introduced into the decision-making process. For example, costs and tastes are more likely to change in the long run than in the short run. New firms may enter the industry, thus changing the demand curve, if they *believe* that there are profits to be made. Existing firms must decide whether (1) to increase their advertising budgets in an attempt to improve the attractiveness of their products, (2) to improve the product itself, and (3) to increase their plant capacities. In making each of these decisions, the firm must recognize uncertainties affecting both the costs of, and the demand for, their products.

Oligopoly is closely related to monopolistic competition. The major difference is that a few firms dominate the industry, which means that if one firm cuts its prices, changes its advertising budget, or takes other steps to increase its share of the market, it should expect its competitors to react but, unless there is collusion, it cannot tell exactly *how* they will react. Consequently, another risk is introduced into the decision-making process. Economists have

devoted much attention to studying the different assumptions that a firm may make with respect to its competitor's reactions, but it is sufficient here to note the existence of risk in this situation.

In most economic discussions of price and output determination, the effects of speculative risks upon the decision are usually explicitly recognized.[3] These effects may be favorable or unfavorable. As stated in Chapter 1, out of uncertainty spring discussion, hope, planning, accomplishment, and progress. But uncertainty also gives rise to dispute, fear, defensive tactics, failure, and retrogression. Pure risks, which have only negative effects, are usually at most treated implicitly. This is unfortunate, because pure risks clearly affect the firm's average cost curve. Failure to recognize the possibility of certain pure losses may cause the actual costs per unit of output to be substantially larger than forecast. If the firm recognizes these potential losses and decides to retain them if they should occur, it will make some allowance for a possible shift in its cost curve, but the nature of this allowance is likely to vary greatly among firms, depending upon their estimates of the degree of risk, the value of the risk, and their attitudes toward risk. As a result the general price level will be higher and the relative prices charged by different firms and different industries are likely to be different from what would be true in a riskless economy. Because businesses are more reluctant to commit their resources to ventures toward which they have a high risk aversion, the economy is likely to develop less than optimally. If the firm buys insurance against these losses, the costs are increased a definite amount for each unit of output. Uncertainty *with respect to this risk* is eliminated, but the business must decide whether the benefits derived from the elimination of this uncertainty equal or exceed the price of the insurance.

Pure risks also affect the expected demand for the product. A spell of unusually cold weather can reduce the demand for a certain product; a riot in the neighborhood may at the same time cause damage to a firm's property and discourage customers from entering the premises; or serious physical damage may cause the firm to interrupt its business for so long a period that its customers transfer their allegiance to a competitor. The demand is also affected by the pure risks faced by customers whose economic status and attitudes toward their own pure risks influence their buying behavior.

Pricing and Employment of Land, Labor, and Capital. In addition to determining what price it should charge for its product and what its output should be, each firm must decide what combination of resources (land, labor, and capital) it should use and what price it should pay for each resource. Although

[3] For example, see *ibid.*, p. 514.

economists acknowledge that various institutional factors, such as labor unions and minimum wages, cannot be ignored, they suggest the following model for understanding many resource-pricing and employment decisions.

As the firm increases the quantity of a given resource it employs, its total product and revenue tend to increase but at a decreasing rate. Consequently, its marginal revenue product (the additional revenue produced by the last unit employed) tends to decline as its employment of that resource increases. On the other hand, as more of the resource is employed, it becomes more scarce and more costly. In order to maximize its profits, the firm should employ this resource up to the point where its marginal revenue product equals the marginal cost of employing one more unit of that resource.

As was true in the price-output determination, risk complicates this decision because the firm must estimate the demand and supply schedules for the resource involved. Pure risks as well as speculative risks influence and can upset the firm's expectations. Distortions in the pricing and allocation of resources may be the result. The purchase of insurance can reduce these uncertainties, but the cost of the insurance may exceed its value to the firm.

Profit Theories. Economists have devoted considerable attention to the role of profits in our economy. To the economist profits are "what remain after both explicit and implicit wage, rent, and interest costs have been subtracted from a firm's total revenue."[4] Economists recognize that the owners could have employed their capital (and perhaps their land and labor) in other uses and that this opportunity cost should be considered in calculating profits.

Profits are considered to be (1) a reward for assuming risks or (2) the result of monopoly power. The first source of profits is of much greater interest here. Profits are assumed to arise, first, because in a dynamic economy changes in technology, tastes, and other factors external to the firm are constantly upsetting demand and cost expectations. Even when conditions remain fairly stable, entrepreneurs differ in their ability to estimate the existing revenue and cost situation. Profits may also result from innovations introduced by individual firms in order to influence favorably their expected costs or revenues. Often, however, these innovations result in losses instead of profits. Thus risk is associated with innovations. Of course, failure to innovate also involves risk.

Economists usually claim, however, that it "is the bearing of uninsurable risks . . . which is a potential source of economic profits."[5] The bearing of insurable risks is not considered to be a potential source of profits because

[4] *Ibid.*, p. 584.
[5] *Ibid.*, p. 585.

the entrepreneur can avoid these risks by paying a definite premium. Perhaps the first writer to make this distinction was the distinguished economist, Frank Knight, whose "Risk, Uncertainty and Profit" remains one of the classic treatments of the role of risk in economics.[6] According to Knight, a person is exposed to risk when he does not know exactly what will happen in the future but he can determine *a priori* or empirically what the probability is for each of the possible outcomes. A person is exposed to uncertainty when he does not know the future outcome or the probabilities of the various outcomes. Risks, he claimed, are insurable; uncertainties are not. Only uncertainties create an economic problem and can be the source of economic profit.

Such a dichotomy oversimplifies the true situation, because insurance actuaries must often use considerable judgment in establishing insurance premiums.[7] Insureds are even less well informed concerning their probability of loss. Sometimes insurers can estimate the probability of a loss of a certain type but they sell little or no insurance against these losses because the premium would be too high relative to the potential loss for this insurance to be economically feasible. Many pure risks are not insurable because it is extremely difficult to measure the expected losses.

Are management decisions with respect to pure risk a source of economic profit? Certainly firms do make different decisions with respect to the handling of pure risks and their profits are affected by these decisions. Insurance will not and should not be purchased against every pure risk. It seems reasonable to argue that the proper handling of pure risk may also be a source of economic profits.

Decision Making Under Uncertainty. One of the models developed by economists to explain decision making under uncertainty is an expected-utility model.[8] Some economists argue that this model provides an adequate description of how people do behave; others advance the model as a prescription for how they should behave.

Expected monetary values are not an adequate guide to action because they do not recognize, among other things, the person's aversion to risk and the fact that as a person's wealth increases, the satisfaction that he derives from that wealth tends to increase less than proportionately. To illustrate, assume that a person who currently commands a wealth of $20,000 is subject to a

[6] Frank H. Knight, "Risk, Uncertainty and Profit."

[7] In an authoritative volume on insurance and economic theory, Professor Irving Pfeffer attributes this oversimplification to the "fallacy of actuarial perfection." Irving Pfeffer, "Insurance and Economic Theory," p. 5.

[8] For a brief description of the views of several leading economists concerning decision making under uncertainty, see James L. Athearn, "Contributions to Risk and Insurance Theory from the Field of Economics."

potential loss of $10,000, for which the probability of loss is $\frac{1}{10}$. An insurer is willing to protect this person against this loss for a premium of $1,500. If this person's objective is to maximize his expected monetary value, he will decide not to purchase insurance. The supporting computation is presented in the table below which shows in the first two columns the person's wealth depending upon the action he takes and the loss outcome and in the third column the expected dollar value of his wealth associated with each action.

Action	No loss	Loss	Expected dollar value
Do not buy insurance	$20,000	$10,000	$\frac{9}{10}(\$20{,}000) + \frac{1}{10}(\$10{,}000) = \$19{,}000$
Buy insurance	$18,500	$18,500	$18,500

This person prefers to retain the risk because his estimated expected dollar loss of $1,000 is less than the $1,500 he must pay each year if he buys insurance. The insurer may be estimating an expected loss of less than $1,000, but it must include in its premium a loading for expenses, profit, and contingencies. As implied on p. 21, a person wishing to minimize his average dollar loss in the long run will not purchase insurance unless his estimated expected loss exceeds the insurer's estimate by an amount equal to the expense and profit loading. However, the dollar values in the table may not bear the same relationship to one another as the satisfactions derived from these dollar values. More importantly, this approach ignores the amount the person may be willing to pay to rid himself of the risk that will be present if he decides not to purchase insurance.

The expected-utility model answers these objections by associating with each possible dollar value a "utility value." For example, assume that in the problem under consideration the utility values are as follows:

Wealth	Utility value
$ 0	0
10,000	100
18,500	148
20,000	150

The resulting utility functions "reflect an indecomposable mixture of attitude toward risk, profit, and loss in a particular kind of situation."[9] The person's

[9] Robert Schlaifer, "Probability and Statistics for Business Decisions," p. 42. On pp. 32–43 Schlaifer describes how a person's utility function might be derived. See also the Mosteller-Nogee experiment described on pp. 36–37 of this text.

attitude toward the risk in the particular situation is the most important factor determining the shape of the utility function, but the satisfaction associated with varying amounts of wealth is also a factor.[10] A person's aversion to risk in turn depends upon his assessment of the degree of risk inherent in the particular situation, the magnitude of the potential loss, his economic status, and his general attitude toward uncertainty.

If the person has a high aversion to risk, his utility values increase less than proportionately with increases in his wealth. The utility function shown above has this general shape. Such utility functions are said to be characterized by diminishing marginal utility because the additional satisfaction produced by an additional unit of wealth decreases as the total wealth increases. The greater the person's aversion to risk, the greater the rate at which the marginal utility diminishes. For persons who are indifferent toward risk, the marginal utility is constant for all wealth values; i.e., the utility values increase proportionately with increases in wealth. In this case there is no need to convert dollar values to utility values. For persons who enjoy risk, the marginal utility increases with increases in wealth; i.e., the utility values increase more than proportionately with increases in wealth. Most persons are believed to have negative attitudes toward risk in most situations involving potentially large losses.

Under the expected-utility model, after the decision maker assigns utility values to each of the possible outcomes for each possible decision, he estimates the probabilities for each of these outcomes. Finally, for each possible decision, he computes the expected utility value. The process is the same as the expected-dollar-value computation illustrated earlier. The only difference between the expected-dollar-value model and the expected-utility model is that utility values are used instead of dollar values. That decision is judged best that maximizes this expected utility.

Applying this model to the problem under consideration produces a decision to buy insurance. The supporting calculations are as follows:

Action	No loss	Loss	Expected utility value
Do not buy insurance	150	100	$\frac{9}{10}(150) + \frac{1}{10}(100) = 145$
Buy insurance	148	148	148

An alternative formulation would require the insured to *minimize* his expected *loss* in utility. The decision table in this case would be the following:

[10] For a formulation of the decision-making process that separates the effect of these two components, see C. A. Williams, Jr., and R. M. Heins, "Risk Management and Insurance," pp. 60–66.

Action	No loss	Loss	Expected loss in utility
Do not buy insurance . . .	150 − 150 = 0	150 − 100 = 50	$\frac{9}{10}(0) + \frac{1}{10}(50) = 5$
Buy insurance . .	150 − 148 = 2	150 − 148 = 2	2

Generally it is easier to use this alternative formulation.

Thus the expected-utility model shows that a person may purchase insurance even if the premium exceeds the insurer's estimate of the expected losses if (1) his estimate of the expected losses exceeds that of the insurer or (2) his utility function is characterized by diminishing marginal utility. A utility function may have this characteristic because (1) the person has an aversion to risk or (2) he derives less additional satisfaction from each increment in his wealth.[11]

Macroeconomics and Risk

Risk is also a vital ingredient in the study of macroeconomics. The business cycle, the effect of increased taxes and government spending upon private investment and consumption, the response of the economy to higher commercial bank reserve requirements and rediscount rates, and the relationship between protective tariffs and international trade illustrate the wide variety of macroeconomic subjects involving risk. Pure risks, however, play a much more important role in microeconomics than in macroeconomics.

RISK AND PSYCHOLOGY

Because psychology is the science of human and animal behavior,[12] it is not surprising to find that some psychologists have concentrated their attention on the behavior of individuals in situations involving risk. Three problems arise in discussing the relationships between psychology and risk. First, as

[11] In a frequently cited article on the analysis of choices involving risk, Friedman and Savage have argued that the utility function of money is characterized by "diminishing marginal utility of money income for incomes below some income, increasing marginal utility of money income for incomes between that income and some larger income, and diminishing marginal utility of money for all higher incomes." Milton Friedman and L. J. Savage, "The Utility Analysis of Choices Involving Risk," p. 303. Such a utility function can be used to explain (1) why the same person may, depending upon the odds and the values at stake, be on different occasions a gambler and an insurance prospect and (2) why risk attitudes vary among economic classes. This article, however, employs an older concept of utility under which utility values depended solely upon the satisfaction associated with various amounts of wealth.

Irving Pfeffer has termed this explanation inadequate because persons are influenced at least as much by whether their objective is a wish for recreation or a desire for security. Irving Pfeffer, *op. cit.*, p. 144. In other words, a person's risk-aversion index is a more important factor.

[12] Clifford T. Morgan and Richard A. King, "Introduction to Psychology," p. 4.

was true for economics, risk is so pervasive that in the broad sense all psychology is concerned with risk. Attention will be limited here to a few studies in which the role of risk was made explicit. Second, because the literature in this field is so extensive, only a sampling will be presented. Third, although "behavior is the subject of psychology, it is by no means the exclusive property of psychology. Several other disciplines make the study of human and animal behavior their business. These include psychiatry, anthropology, sociology, economics, political science, and history. Taken together, these have recently come to be called the *behavioral sciences*. Each of them focuses its attention upon certain aspects of behavior, although differences among them are not always clear cut."[13] In what follows the overlap with economics is particularly noticeable.

The topics to be considered in this brief treatment include utility, subjective probability, and some factors affecting attitudes toward risk.

Utility and Subjective Probability

From the description of the expected-utility model on pp. 32–35, it is apparent that one cannot make a decision in this way unless one knows the shape of his utility function. It is also impossible to determine whether in fact an individual makes decisions according to this model. Consequently, economists and psychologists have conducted many experiments designed to measure an individual's utility function and to determine whether people do in fact try to maximize their expected utility.

One of the most famous early attempts to measure utility was an experiment conducted by Mosteller and Nogee to check some of the arguments presented in the work of Friedman and Savage cited on p. 35.[14] The two experimenters administered their experiment to three groups of five subjects each. Two of the groups were Harvard College undergraduates; the third group consisted of National Guardsmen. Each subject was given $1 at the beginning of each of several sessions. During each session the experimenter would present the subjects with the results of a roll of five dice. Each subject would then decide whether he wanted to try to beat this "hand" by throwing the dice, the cost of losing being a nickel and the reward for winning being some amount, say $.10 or $8, that varied randomly during the course of the experiment. The interest of the experimenters centered on whether the subjects chose to play. If, as assumed, these subjects behaved according to the expected-utility model, they would bet if the sum, (probability of winning) (utility of reward) + (probability of losing) (utility of −$.05), were greater

[13] *Ibid.*, p. 5.

[14] Frederick Mosteller and Philip Nogee, "An Experimental Measurement of Utility."

than zero. They would reject the bet if this expected utility were less than zero. The lowest reward offered was such that the expected *dollar* value would be less than zero; the highest reward offered yielded an expected dollar value greater than zero. The subjects were told the probability of beating each hand. Thus presumably their decision to bet or not to bet was based upon their utility function.

For each hand there were seven rewards, and each hand-reward combination was presented 14 times. When the highest reward was presented, each subject always chose to play; when the lowest reward was presented, he chose not to play. For rewards between these two extremes, he *sometimes* chose to play, the proportion of times increasing as the reward increased. The experimenters then charted the proportion of times each subject chose to play for each reward. From the resulting curve, they estimated the reward for which the subject would probably be indifferent; i.e., he would choose to bet about half the time. In other words, the expected utility for betting on this indifference reward was zero. Therefore, for this reward,

$$\begin{pmatrix}\text{Probability}\\ \text{of}\\ \text{winning}\end{pmatrix}\begin{pmatrix}\text{Utility of}\\ \text{indifference}\\ \text{reward}\end{pmatrix} + \begin{pmatrix}\text{Probability}\\ \text{of}\\ \text{losing}\end{pmatrix}\begin{pmatrix}\text{Utility}\\ \text{of}\\ -\$.05\end{pmatrix} = 0$$

The objective probabilities were known, the utility of $-\$.05$ was assumed to be -1, and the utility of zero assumed to be 0. Consequently it was possible to compute the utility of the indifference reward.

Because several hands were presented, utility values were developed for each subject for a number of indifference rewards on the basis of which it was possible to sketch a utility function. Mosteller and Nogee then used these functions to predict how the same subjects would behave in more complicated wagers and concluded that these "predictions are not so good as might be hoped, but their general direction is correct."[15]

The utility curves varied greatly among the subjects. The student subjects, however, tended to be "conservative," their utility functions indicating a diminishing marginal utility of money. The National Guardsmen tended to be "extravagant," their utility functions being characterized by increasing marginal utility of money.

Preston and Barrata conducted a similar experiment in which they asked subjects to bid competitively with play money for the privilege of taking a bet.[16] The winning bid sometimes exceeded and sometimes was less than the expected *dollar* value of the bet. For example, if the prize was $50 and the

[15] *Ibid.*, p. 399.

[16] M. G. Preston and P. Barrata, "An Experimental Study of the Auction: Value of an Uncertain Outcome."

probability of winning was 0.01, the expected dollar value was 0.99($0) + 0.01($5) = $.05, but some subjects were willing to pay $.51 to play this game. Mosteller and Nogee would have explained this result in terms of the subjects' utility functions, but Preston and Barrata assumed that for all of their subjects in the range under investigation the utility function was characterized by constant marginal utility. Consequently they explain their results by differences between the subjects' subjective probabilities and their corresponding objective probabilities. They concluded that:

1 When the objective probability is low, subjects tend to use a higher subjective probability.
2 When the objective probability is high, subjects tend to use a lower subjective probability.
3 For most subjects the indifference point (the point where the subjective probability equals the objective probability) in the game studied was in the neighborhood of 0.20.

It might be argued that the Preston and Barrata results arise from the assumption that dollar values can be substituted for utility values, but Ward Edwards, who has conducted many experiments on risky choices, has shown that subjects prefer some subjective probabilities to others and that these preferences cannot be explained by utility considerations.[17] Edwards asked over 100 college students to select one of two bets, each student being presented with several pairs of bets. The rewards and losses were so designed that each pair of bets had the same expected dollar value. When these expected values were positive, Edwards found a definite preference for betting when the probability of winning was ½. When the expected value was negative, his subjects usually preferred the bet with the lower probability and higher amount of loss to one with a higher probability of losing a small amount.

Edwards and others have also observed that subjective probabilities may not be subject to the same laws of addition and multiplication as objective probabilities. For example, if subjects do tend to overestimate small probabilities, the sum of the probabilities of a large number of events, each of which has a small probability of occurring and one of which must occur, will exceed 1.

In an experiment with school children Cohen discovered "an inability to regard an independent event as separate and detached from a series of similar

[17] For a brief discussion of his results, see Ward Edwards, "The Theory of Decision Making."

For a more recent statement, see Ward Edwards, "Subjective Probabilities Inferred from Decisions."

events in which it occurs."[18] He calls this inability the phenomenon of Subjective Pseudo-dependence. For example, his subjects were asked what the result of the next toss of a coin would be if each of the last eight tosses had resulted in a head. About 15 per cent of a group of children twelve to thirteen years of age and 27 per cent of a slightly older group recognized that the result on the next toss was independent of the result on the previous tosses.[19] A coin has no memory and the probability of a head on the next toss is ½. Over half of the other subjects, however, maintained that the coin would turn up tails on the next toss because it was time for this to happen. Those subjects who believed that the result would be another head usually argued that the tosser was lucky or skillful. On the basis of this and other experiments Cohen concludes that we tend to overestimate the probability of success when we feel lucky, shrewd, clever, or capable of handling the task before us.[20] Sometimes the fact that the tide has been running against us intensifies our belief that our luck will improve on the next trial.

Many persons argue that gambling itself has a utility or disutility that has been ignored in much experimentation. A recent experiment by Royden, Suppes, and Walsh represented the first systematic attempt to measure this utility.[21] The results suggested that gambling itself does have utility, but it varies among people and depends upon such factors as the expected dollar outcomes and the standard deviation of the potential results.

Psychologists warn us that human beings are neither perfectly consistent nor sensitive to small changes.[22] They emphasize the limitations in their experiments, but even their simplified models add to our understanding of decision making under uncertainty.

Factors Affecting Risk Attitudes

Many experimenters have focused their attention upon the factors that cause subjects to make different decisions under uncertainty. What personality traits or environmental conditions are likely to be associated with a willingness to assume risk? Some of the more interesting results are summarized below:

1 Wallach and Kogan constructed a "deterrence of failure" index for subjects who varied by age and sex.[23] The index was determined by asking

[18] J. Cohen and M. Hansel, "Risk and Gambling," p. 10.
[19] *Ibid.*, pp. 25–28.
[20] J. Cohen, "The Measurement of Uncertainty."
[21] H. L. Royden, P. Suppes, and K. Walsh, "A Model for the Experimental Measurement of the Utility of Gambling."
[22] Edwards, *op. cit.*, p. 388.
[23] M. A. Wallach and N. Kogan, "Aspects of Judgment and Decision Making: Interrelationships and Changes with Age."

each subject what minimum probability of success he would require (1/10, 3/10, 5/10, 7/10, 9/10, or 10/10) in each of 12 life situations before he would accept the more risky of two alternatives. The higher the sum of the required probabilities, the higher the index. The findings indicated that the disutility of failure increases with age for both sexes, but that, whereas this increase may occur gradually for women, it tends to happen abruptly to men. Wallach and Kogan speculate that this difference between the sexes may be associated with the greater impact of retirement upon men. The scores for younger men were almost the same as for the younger women. Older men also scored about the same as older women.

2 The effect of education and intelligence upon risk taking is not clear. One experiment showed an inverse relationship between intelligence and the risk a person is willing to accept;[24] another indicated a positive relationship between good grades and risk taking.[25] Preston and Barrata found that mathematicians, statisticians, and psychologists who were well acquainted with probability overestimated and underestimated objective probabilities to the same degree as their other subjects.[26]

3 Torrance and Ziller found a close relationship between certain personality traits as measured by a biographical inventory and the willingness to select the more risky alternative in a military situation.[27] In general, risk takers learned skills such as dancing or driving a car early, were born in small towns or on farms, were more independent, enjoyed and were good at physical activity, were socially aggressive, enjoyed competition and bets, gave free expression to their sexual drives, and were divorced and remarried.

4 Many psychologists have argued that man does not necessarily strive to achieve the optimum result. The immediate objective may be a "satisfactory" outcome. If this outcome is achieved, the next goal may be a *more* satisfactory outcome.[28] Consequently they argue that in experiments it is not always reasonable to assume optimum behavior with respect to risk taking.

People also differ in their level of aspiration, which may affect the amount of effort they will put forth in making a decision and their willingness to take risk. Some people set levels just a little above their probable level of performance. Others set goals that it is impossible for them to

[24] A Scodel, P. Ratoosh, and J. Mines, "Some Personality Correlates of Decision Making under Conditions of Risk."

[25] D. Kipnis and A. S. Glickman, "The Development of a Non-cognitude Battery: Prediction of Radiomen Performance."

[26] Preston and Barrata, *op. cit.*, p. 193.

[27] E. P. Torrance and R. C. Ziller, "Risk and Life Experience: Development of a Scale for Measuring Risk-taking Tendencies."

[28] H. A. Simon, "Theories of Decision-making in Economics."

attain because they seek approval for the goals themselves. Still others set goals below their abilities because they fear failure.[29]

5 In a recent book-length treatment of "Risk Taking,"[30] Kogan and Wallach emphasize the complexity of the decision-making process, but they believe that a person's willingness to assume risk and his consistency in this behavior are influenced greatly by (1) his "test anxiety" or his desire to avoid failure and (2) his "defensiveness" or the degree of his concern with maintaining his image.

6 Wallach, Kogan, and Bem conducted a study in which they determined "deterrence of failure" indexes for individual subjects and for groups composed of these individual subjects. The indexes for the groups were significantly lower than the average individual index for the subjects in the group. Perhaps the individuals with lower indexes are the more persuasive members of the group or perhaps people are more willing to take chances when their individual responsibility appears less.[31]

7 Hermann and Stewart discovered that their subjects underwent a definite change in their willingness to gamble as they participated in a game involving wagers. The subjects became increasingly conservative when they were winning. They took greater chances when they were losing.[32]

Implications for the Theory of Pure Risk

Professor Mark Greene has reported on an experiment in which he measured attitudes toward risk by a "deterrence of failure" test similar to that of Kogan and Wallach and by the Torrance-Ziller biographical inventory test.[33] Scores on these tests were correlated with one another and with the scores on an insurance-mindedness test which was designed to measure probable insurance-buying behavior. Although Greene warned that his conclusions were tentative, he found no significant relationship between the two sets of risk-attitude scores or between each set of risk-attitude scores and insurance-mindedness.

A more recent experiment indicates that attitudes toward speculative risks may not be a satisfactory indicator of pure risks.[34] For example, one group of graduate students in business administration was unwilling to participate

[29] Morgan and King, *op. cit.*, p. 234.

[30] N. Kogan and M. A. Wallach, "Risk Taking."

[31] M. A. Wallach, N. Kogan, and D. J. Bem, "Diffusion of Responsibility and Level of Risk Taking in Groups," *Journal of Abnormal and Social Psychology*, vol. 68, no. 3 (March, 1964), pp. 263–274.

[32] C. C. Hermann and J. B. Stewart, "The Experimental Game."

[33] Mark R. Greene, "Attitudes toward Risk and a Theory of Insurance Consumption."

[34] C. A. Williams, Jr., "Attitudes toward Speculative Risks as an Indicator of Attitudes toward Pure Risk."

in a venture that presented a possible gain of $100 and a possible loss of $4,900 unless the probability of winning was at least 0.99; i.e., the probability of losing was 0.01 or less. On the other hand, they were unwilling to pay a fee of $100 to avoid a loss of $5,000 unless the probability of loss was 0.10 or more. Otherwise they preferred to assume the risk of a gain of $100 (the premium saving) or a net loss of $4,900 (the $5,000 loss less the premium saving). The experiment was a crude one, but it suggests the need for additional psychological experiments in which the subjects are required to make decisions involving pure risks.

RISK AND BUSINESS ADMINISTRATION

The study of business administration is an interdisciplinary venture. The behavioral sciences and mathematics have proved particularly useful in shedding new light on the traditional fields of accounting, business statistics, management, finance, marketing, production, and industrial or personnel relations. The role of risk in two of these behavioral sciences—economics and psychology—and in statistics, a close relative of mathematics, has already been discussed. Attention will be directed here to the place of risk in management, financial management, production management, marketing management, and personnel management.

Management

The process of managing a business consists of (1) organizing, (2) planning, (3) leading, and (4) measuring and controlling.[35] Organizing involves such tasks as dividing the operating work into manageable units, dividing the managerial work, and determining the proper role of staff people. Matching jobs and individuals, blending power and influence, and harmonizing informal social groups with the formal organization are objectives that no manager can be certain of attaining.

Planning includes diagnosis of the problem or the objective, development of courses of action for solving the problem or achieving the objective, comparing these courses of action, and choosing among them. Uncertainty is ever-present because the manager's information is often incomplete or unreliable and the results of certain courses of action can usually only be guessed. In making these plans the manager must also determine the optimum extent to which he should invite his subordinates to participate in the planning process. The answer is by no means obvious.

[35] W. H. Newman, C. E. Summer, Jr., and W. E. Kirby, "The Process of Management."

The primary functions of a leader are to understand the feelings and problems of his subordinates and to guide and maturate their behavior. He must develop voluntary cooperation, encourage two-way communication, and reward and discipline his workers. The leader faces many uncertainties in these efforts.

Once the business enterprise is under way, its performance must be measured against some standard and, if the performance is not satisfactory, the manager should seek corrective measures. Uncertainties arise concerning the proper standard, the measurement of performance, and the proper way to correct any deficiencies.

In short, the management process is fraught with uncertainty. Risk theory is important to management theory, and vice versa.

There follow some specific illustrations of the role of risk in financial management, production management, marketing management, and personnel management.

Financial Management

Financial management is concerned with forecasting the need for funds, raising these funds, and administering them. The need for funds depends upon variables that are subject to considerable risk. Raising and administering funds involves such uncertain decisions as the mix of short-term, intermediate, and long-term financing; the ratio of debt to equity financing; dividend policy; the ratio of current assets to fixed assets; and the use of leased property instead of buying property.

Capital budgeting or choosing among alternative uses of capital funds is one of the major subjects in accounting and financial management. For each potential use, the return on the investment is computed and compared with the cost of capital. The financial manager then favors those uses with the highest ratios of return to cost. This decision is complicated by the uncertain returns and costs that must be considered, and considerable attention has been directed in the literature to this problem.

Hedging on the stock exchange is another subject in finance in which the role of risk is made explicit. An investor owning shares of a certain stock may try to protect himself against a decline in the price of this stock by a "short" sale at the existing price. The seller sells borrowed stock which he must replace at some future date. If the price is higher in the future, he loses money on the short sale but gains on the stock he owns. If the price declines, he gains on the short sale but loses on his own holdings.

Other examples of hedging such as puts and calls could be cited. Indeed, the entire subject of investing is a study of decision making under uncertainty.

The management of pure risks is usually the responsibility of someone in the finance division of the business. The role of this *risk manager* is discussed in the next chapter. Pure risks are important to financial managers because an unexpected fire, liability suit, or death can upset financial expectations. Failure to plan for such potential losses may discourage potential investors or creditors. The work of the risk manager in turn is supplemented by such financial-management functions as internal controls to reduce the probability of employee dishonesty, the valuation of property, and information concerning the financial impact upon the firm of various types of losses.

Insurers are important financial institutions. As sources of long-term capital funds they are of major interest to financial theorists.

Production Management

Production management is concerned with the proper combination of men, material, and machines to produce the products of a business. This combination depends upon the supply of the basic resources, their prices, and the results of the various ways in which they can be combined to produce the product. The supply and the prices of the inputs change, and the output resulting from a particular combination of inputs is not always the same; resources vary in quality and the same resource varies over time in its productivity. One illustrative production question involving risk is the proper level of inventories. If the inventory of raw materials is kept low, the production process may have to be halted at some time, or there is the risk that the cost of replenishing the supply may rise. If it is kept high, valuable storage space may be wasted, handling costs may increase, and raw material costs may fall. Production theorists have developed some powerful operations-research techniques for dealing with these problems, but uncertainty remains an important factor.

Pure risks must be considered by the production manager in his planning. For example, the loss of a critical machine may stop the production process. The production manager can also contribute to the reduction of pure losses through various loss-prevention-and-reduction measures such as healthful working conditions, reasonable production goals, machine safeguards, and instruction in the careful use of equipment.

Marketing Management

Marketing managers are concerned primarily with the demand for the products of a business. They must forecast the existing demand, estimate how it is likely to change in the future, and devise ways in which they might increase that demand. Increasing this demand involves such matters as advertising

budgets and media, channels of distribution, compensation for their selling agents, and price policies. Like the financial manager, the marketing manager charged with purchasing decisions must consider the opportunities for hedging against price changes, particularly on organized commodity exchanges. A cotton manufacturer faced with the possibility of a price change in the cost of his raw material which may be reflected in the cost of his manufactured product should consider the possible advantages in agreeing today to sell cotton to someone else in the future at an agreed price. Hedging almost never works perfectly, but theoretically if the price of cotton does change, the resulting increase or decrease in the price of the manufactured article will be offset by the gain or loss on the futures transaction. The importance of risk theory in these marketing decisions is clear.

Pure risks can upset the expectations of the marketing department. For example, an interruption in the production process because of windstorm damage can disrupt customer relations and marketing channels. Marketing departments may also aid the risk manager in controlling pure risks. For example, in their zeal to increase sales for the company, members of this department may make exaggerated claims for the company's products that cause accidental losses for customers and lead to liability suits. Hold-harmless agreements (discussed in Chapter 8) may require the firm to bear responsibility for accidental losses that would ordinarily be borne by selling agents or customers. If the marketing department is aware of these problems, it may take steps to reduce the risks associated with these practices.

Personnel Management

Personnel management includes such matters as the selection of personnel and their assignment to the proper job, the determination of compensation levels and other rewards that are appropriate for each job and each person, the training of personnel, and collective bargaining. Risks are present in each of these tasks.

Personnel managers contribute to the management of pure risks by the fact that well-trained, motivated, and able personnel are more likely to turn out nondefective products with a better safety record. Personnel managers are usually directly concerned with employee-benefit plans (described in Chapter 23) that are designed to protect employees against certain pure risks.

QUESTIONS

1 How can pure and speculative risks upset the plans of a firm intending to establish its prices and output according to the usual economic model of a firm operating under conditions of monopolistic competition?

2 How would the existence of risk affect the price charged by a oligopolist?

3 What is the role of pure and speculative risks in the economist's explanation of profits?

4 A person's utility function is such that his present position is valued at 500 utils. A loss of $20,000 would reduce his utility to 200 utils. For a definite premium payment of $400, which would reduce his utility to 495 utils, he can transfer the risk of this potential loss to an insurer. The chance of loss is $\frac{1}{100}$.

   a If his objective is to minimize his expected dollar loss, should he purchase the insurance?

   b If his objective is to minimize his expected loss in utility, should he purchase the insurance?

   c What factors influence the shape of his utility function?

5 Evaluate psychologists' attempts to measure utility functions.

6 What factors may cause a person's subjective probability to differ from his objective probability? Cite experimental evidence for these factors.

7 What types of person would you expect to have a low aversion to risk? Cite experimental evidence for your beliefs.

8 How valuable are the results of psychological experiments involving risk in the study of pure risk?

9 "The management process is fraught with uncertainty." Explain the basis for this statement.

10 Which of the functional areas of management is most concerned with risk? with pure risks?

4
RISK MANAGEMENT

Risk is a problem of management—in the affairs of the individual, of the family, or of business. It has been neglected, but slowly it is achieving recognition, particularly in business. Although all types of risk must be managed, it is intended in this chapter and in the remainder of this text to deal only with the management of pure risks. There will be discussed the rise of the (pure) risk manager, his functions, some principles he should follow in carrying out his assignment, the qualifications he should possess, and some of the problems he faces.

DEVELOPMENT OF RISK MANAGEMENT

Early Attitudes

Until the 1930's little thought was given to risk as a specialized problem worthy of high-level consideration and planning. Many businesses bought such insurance as was conventionally considered necessary or was sold to them in one way or another. Otherwise intensely practical executives abdicated their authority when questions of risk and insurance arose and left decisions to their brokers or agents, keeping some control over amounts expended in premiums. What records were kept and what planning was done were usually assigned to some minor figure in the office of the treasurer of the controller. But there was little analysis of the risk problem and little planning to meet it in detail. What was done can only be described as generally haphazard.[1] Much insurance was placed on the basis of friendship or financial pressure.

Insurance against loss of physical property by fire, and liability and required

[1] These comments do not apply to marine insurance nor to some of the larger businesses that were pioneers in the recognition and management of risk.

compensation insurance, with, occasionally, marine insurance and bonds were the common answers to the risk problem, though the cost of compensation insurance had developed considerable interest in accident prevention.

The individual insured his property against loss by fire, at considerably less than its replacement cost. If he was prudent, he bought automobile insurance, and whatever life insurance he felt he could pay for or an agent could induce him to buy. In some cases he carried accident insurance and even sickness insurance. But he did not plan carefully to evaluate and meet the particular risks to which he and his family were exposed.

Results of Neglect

The results of inattention to risk were what might have been expected. They became evident when losses occurred. Inadequate programs of prevention or insurance may coast along for considerable periods without giving evidence of their inadequacy, if no loss or only minor losses occur. It is only when an important loss occurs, or when a succession of minor losses adds up to a significant total, that the risk program is tested.

In 1925, the National Retail Dry Goods Association set up an advisory insurance department. The department offered its services to survey the insurance problems and the insurance situations of its members. It was found, even in the case of otherwise competently managed enterprises, that managements had dealt with risk almost entirely by buying insurance. And their insurance reflected little careful planning. There were overinsurance and underinsurance; overlapping insurance and gaps that were not covered by insurance; excessive premiums at one point and unwise economy or neglect at another. The surveys easily paid for themselves in improved insurance programs.

Much the same situations existed elsewhere—and could probably be found today where consciousness of the risk problem or proper methods of dealing with it have not been developed.

Rise of the Risk Manager

There are now probably some 2,500 full-time risk managers, though not usually designated by that title. A risk manager is more likely to be called *insurance manager* or *manager of the insurance department.* In the jargon of the trade he is often called *insurance buyer;* too often he limits himself to that function. The term *risk manager* is adopted here to stress the full and proper function in management of the person to whom is, or should be, assigned the responsibility of dealing with risk. The "insurance managers"

who have understood their full function and who have attained their proper place in management are dealing with the risk problem; insurance may be the principal means of meeting it, but it is not the only means. Among full-time risk managers there are wide variations in status, authority, and staff, but the assignment at least indicates recognition of risk as a major problem.

In many business firms, the problem of risk has been recognized to the extent of assigning it to persons who are not made full-time risk managers but who are expected to give a large, or even a major, part of their attention to it.

The opinion of one chief executive, an opinion that reflects his company's policy, follows:[2]

> Forward-looking management has long since come to look upon insurance [risk] as a specialized field far beyond the routine purchase of policies of indemnification. The concept of assigning the functions of insurance management to an already over-burdened company official, such as the secretary, treasurer or controller, is today just as far-fetched as would be the assigning of the legal or operating functions of the company to these same officials. Today, we thus have the full-time insurance executive heading a separate department in the corporate structure—a specialist to whom management can look for the analysis of risks to which its company's physical plant is exposed, the selection of methods through which these risks may be reduced or eliminated, and the procurement of such insurance contracts as will provide indemnification in the event these risks result in financial loss.

The "insurance management" mentioned in this quotation is really risk management as conceived in this chapter, and it deals with risk problems extending well beyond those of the "physical plant."

Risk Managers' Organizations. Evidence of the growth of the risk manager's importance to business is found in the development of his organizations.

Insurance Buyers of New York was organized in 1932. Its members were mostly risk managers of businesses located in the New York metropolitan area. In 1935, it gave way to Risk Research Institute, Inc., a national organization, whose chapter in New York was the successor of the earlier organization. Efforts to promote chapters in other parts of the country were unsuccessful, and, in 1951, the Institute was succeeded by the National Insurance Buyers Association, Inc., now the American Society of Insurance Management, Inc., an Illinois corporation, organized in 1950, with a chapter and headquarters in New York. The principal purposes of the association are to promote close

[2] H. P. Liversidge, "What Management Expects from an Insurance Department," in "Operating Guides for the Corporate Insurance Buyer," p. 4.

relations among insurance buyers, improve insurance protection, compile and distribute information, provide opportunity for discussion, and foster "a reasonably competitive insurance market." It now has 38 chapters in as many regions and is seeking to organize further local chapters. It has 1,602 corporate members.

In 1931, the Insurance Division of the American Management Association was organized and held its first conference. The inspiration for its founding came from a few risk managers, though its membership was, and still is, open to persons having insurance interests of any sort. As with other divisions of the association, it offers a forum for the discussion of insurance questions, but takes no position on any question and has no propaganda or legislative program. From meager beginnings and failure at first to engage the active interest of the insurance business, the division has grown to large proportions and counts in its membership representatives of all phases of insurance, though it is dominated by, and primarily serves, the risk manager. Many conferences are held each year which bring together an increasingly large group for the discussion of questions of risk, almost wholly from the point of view of risk management. The association also conducts "workshop seminars" for the more intimate and intensive study of such questions and publishes informative literature.

Other Agencies of Risk Management

Agents and Brokers. The highest-grade agencies and brokerage organizations render services in the management of risk compatible with their standing, maintaining engineering and even actuarial departments for the benefit of their clients. But they are not a complete substitute for the risk manager and his staff, for no outside organization can have his intimate knowledge, give his continuous attention, have his specialized interest, or so well develop and administer methods peculiarly adapted to his business. Further, agents or brokers can hardly be entirely objective in their attitude toward insurance and the various types of insurers. And decisions on such matters as what risks to insure, what risks to self-insure, what expenditures to make for loss prevention are functions of the risk manager.

This is not to say, however, that the risk manager is a complete substitute for the agent or broker. These middlemen can be, and are, of great service to him in supplementing and checking his own work. Often he will not have the resources to do the thorough job that a fully equipped department could do, and the help of the agent or broker will be invaluable. Their greatest service, however, is probably in exploring the insurance market to effect the insurance required by the risk manager. The largest brokerage organizations have

offices in numerous centers, and the smaller organizations, as well as agencies, have national and international connections. The risk manager may not be in a position to know the market fully and may deal directly with only a segment of it.

Certain agents and brokers specialize in handling particular types of risk, e.g., department stores or cotton, and are equipped to give specialized service.

Independent Counselors. A growing business is that of *insurance counselor.* The counselor is an independent adviser who offers his services for a fee, sometimes based on the saving in premiums that he effects for his client, but usually, and better, a definite amount. At his best, the counselor is concerned with the whole risk problem, but he may limit his services to a consideration of insurance and to recommendations for revising insurance programs.

Insurance counselors are employed by business firms that are unable or unwilling to create the position of risk manager in their own organizations, and by firms that have such managers but consider an outside review to be desirable.

Reasons for Rise of Risk Management

Various causes have contributed to the rise of risk management and of the risk manager. It is hard to say which have been most effective.

Business units have increased notably in size and diversification over the years and have spread their activities over national and international areas. Merely keeping in touch with the ramifications of a big business is a considerable task, to say nothing of evaluating its risk problems and dealing with them. Along with this expansion has gone increasing complexity, as large businesses have undertaken more of the services and production formerly secured from others. And relations with suppliers, consumers, employees, and government have become more complex. Each of these developments has carried with it new or changing aspects of risk.

The hazards to which business is subject have multiplied. Physical hazards have changed and often increased with new materials and products, new processes, new machinery, construction of plants in new locations, new methods of transportation, and the complicated processes of maintaining connections between locations. Juridical hazards have likewise increased in number and intensity. Statutes have developed or created responsibilities; courts have become more liberal to plaintiffs; plaintiffs' lawyers have become more active and skilled; and the public is more given to asserting its rights, actual or imagined.

As new ways for making machines do the work of men are discovered and applied, investment in plant increases, and hence the importance of preserving plant from loss and providing for indemnity if loss comes. At the same time business is operated on smaller margins for profit and contingencies. Both the heavy cost of replacing physical assets and the limited availability of funds for doing so argue for increasing attention to risk and its results. The day of the entrepreneur who saw in the ashes of his plant an opportunity to make a new start and a new fortune is pretty well over.

Meeting risk by preventive methods has become the province of specialized engineers, notably in the field of fire prevention and accident prevention, but elsewhere as well. The methods of the engineer must be utilized as far as practicable, and it is the risk manager's job to determine such utilization.

Insurers, insurance contracts, rating methods—all have responded to these developments with developments of their own. What was once a matter of simple choice has become highly technical.

And not least is the gradual development of the risk manager himself. With the employment of increasingly competent men in the position of risk manager, the tendency to give more careful and more productive attention to a specialized responsibility, and the exchange of ideas among practitioners who recognize common problems, the manager is achieving an understanding of his job and capability in it that were formerly impossible.

FUNCTIONS OF RISK MANAGER

The primary function of the risk manager is determination and analysis of the pure risks tc which the business[3] is exposed. He must learn in detail the nature and extent of his problem and responsibility—what losses are possible.

Logically his first thought should be of prevention of loss (including avoidance of risk), but he must recognize the necessity of protection against the consequences of losses that are not prevented. Some losses cannot be prevented, at least within the limits of practicality, but to the extent that this end can be achieved the problem is solved.

The manager must have evaluations of possible losses, whether made by himself, by another department, or by outside consultants. This is not simply a matter of determining the value of tangible property; it goes much further. In the case of physical property, the question to be answered is, What would the business lose if the property were destroyed? The loss might be zero if the property were surplus that need not be replaced; or it might be more than the depreciated replacement cost if the property were to be replaced with a

[3] Although this discussion is in terms of business, it applies to any organization or person with sufficiently large interests to employ a risk manager.

new structure no better for use than the old one. He must determine the possible loss if a casualty forced a shutdown; the loss that would result from the disability or death of a key executive or specialist; amounts subject to embezzlement or burglary. He must recognize that some possible losses are incapable of advance evaluation, such as those due to liability for damages on account of bodily injury or for workmen's compensation.

Faced with possible loss he must decide whether to ignore it, take steps to prevent it, deal with it as an expected part of expenses of operation, make financial preparation to meet it through self-insurance, or insure against it. He may decide to adopt one of these methods or a combination of more than one. In any case, he must plan and administer his choice of method and be prepared to justify it. Each of these methods will be discussed in more detail in Chapters 5 through 8.

To the extent that he decides to insure against loss—and insurance will be the answer to a large share of his problems—he will have questions of types of insurance, contract provisions, amounts of insurance, types of insurer, individual insurers, use of middlemen, and rating plans. When losses occur, he will have the responsibility of conducting adjustments.

As an aid to, and for the purpose of reporting on, his operations the risk manager must maintain accounting and statistical records. He should be able to check the results of his decisions and activities as a guide to future operation; he should allocate costs to departments or functions of his firm; he needs records to assure efficient day-to-day functioning of his own department.[4]

PRINCIPLES OF RISK MANAGEMENT

In the development of risk management too little attention has been paid to principles—to theory, a much maligned word, in such disgrace as almost to put a ban on thinking. Dismissal of an idea as "theoretical" or "all right in theory but it won't work in practice" is often no more than a refusal to think beyond what is being done, or what can shortly be done. There is great need for careful working out of principles to serve as a guide to the conduct of risk management, as ideals toward which to work, in full appreciation of the limited possibilities of particular situations.

There has been little, if any, attempt to set down these principles, though many may be conscious of them or may unconsciously follow them. In the

[4] For a recent summary of the practice of risk management by practitioners, see "The Growing Job of Risk Management," *American Management Association Report No. 70,* 1962. See also "Supplementary Readings" for use with "Part RM 4—Principles of Risk Management," and "Selected Readings" for use with "Part RM 5—Practices of Risk Management," both published by the Insurance Institute of America.

following paragraphs certain outstanding principles will be stated categorically for the sake of simplicity and because of limited space.

The Point of View of the Loss

All questions of risk should be considered primarily from the point of view of the possible loss, tangible or intangible. What would be its results? How important would it be? What can be done to guard against its occurrence or to mitigate its effects? These and many more detailed questions can best be answered by assuming that the loss has occurred and asking oneself what ought to have been done.

Possibilities vs. Probabilities

The prime consideration in assessing the importance of a risk and determining the attention that should be given to it is the *possibility* of loss connected with it. A loss might be highly probable but of little consequence; the probability of another loss might be slight but should it happen, the consequences would be disastrous. It is with possible consequences that the risk manager should be particularly concerned, whether the degree of probability is high or low. For example, the probability of failure of electric power supplied by a public utility through underground cables in a city is slight, but if failure would result in the loss of highly valuable production dependent on temperature control, the risk of failure demands attention. In some cases the degree of probability may be high and the possible consequences serious, as is true of industrial accidents in a coal mine; again it is the consequences that primarily condition their importance as a matter of risk management. The basic duty of the risk manager is to conserve the assets, actual and potential, of the business that employs him.

Principles Applicable to Specific Situations

Prevention. There is a *prima facie* case for preventing (including avoiding) loss. To the extent that loss is prevented, the risk problem is eliminated or mitigated. And when loss occurs, the best indemnity that can be provided is likely to be inadequate, particularly in the case of a successful going concern. Loss should be prevented to the extent that prevention is practical. Often there is a direct measure of practicality in a comparison of the cost of prevention and resulting reduction in the cost of insurance, or in experienced reduction in losses borne by the business itself. But much of the determination of what preventive effort is practical is a matter of judgment, for not all savings

from prevention can be measured, for example, the effect of a low industrial-accident rate on employee morale or the relations with customers maintained by uninterrupted supply of a product.

A risk manager[5] of long and wide experience writes:

> Prevention has been a function largely imposed on management from outside. Insurers and rating bureaus, state and local authorities, such organizations as the National Fire Protection Association, have by direct order or persuasion overcome some of the resistance of management. But their recommendations and educational material may have reached, for final decision, the treasurer, the master mechanic, or the company attorney—too often the waste basket.
>
> Effective risk management demands *integration* of the prevention function with the usual functions of the risk manager; it calls for origination by his department of prevention measures applicable to the peculiar problems of the business for which he is working.

Self-insurance and Noninsurance. Considered from the point of view of risk bearing, only those risks the results of which might be financially embarrassing should be transferred to an insurer. Losses that can be so closely estimated that the business can bear them itself, either through self-insurance or by absorbing them in operating costs without advance provision, should not be insured against.[6] This principle is subject to numerous qualifications. A firm may insure risks that it could perfectly well bear itself, not so much to protect itself against financial loss as to secure the service that accompanies the insurance. Or as a matter of business policy it may prefer to turn over settlement of claims to an insurer. In some cases risk bearing may be divided, losses beyond those which the business bears itself being insured against. A firm might decide that it could bear up to $50,000 of workmen's-compensation losses in any one year and might insure only against losses in excess of that amount. Or it might bear the first $5,000 of any one loss from fire or from windstorm. This question of retention and self-insurance is considered in more detail in Chapter 8.

How Much Insurance? Full insurance, from the point of view of the insured, is the amount that would indemnify the insured's *real* loss, which may or may not be the loss that he could collect under the terms of an insurance contract. The point can best be made by illustration. A firm has cut the timber on a tract of woodland and has manufactured lumber which it has shipped to dis-

[5] Henry Anderson.
[6] See pp. 92.

tributing centers. It had been necessary to erect buildings for the accommodation of the workmen on the project, buildings which are now abandoned and which would not be replaced were they destroyed. Their destruction would involve no *real* loss to the firm, and they should therefore not be insured. At the other extreme, a firm owns a warehouse that is essential to its operation. No funds have been accumulated to offset depreciation of the building. Were it destroyed a new building of the same design and construction would be immediately needed. Full insurance against *real* loss would equal the cost of replacement *new* of the building, plus any extra expenses incurred for a substitute warehouse. Or a man owns an old barn in the country which he uses to house his car. It would cost $8,000 to replace it, allowing for depreciation, but he would actually replace it with a garage that would cost $4,000 new. Full insurance would amount to $4,000.[7]

Insurance against other than *real* loss is not a "good gamble." Assuming that premium rates are accurate (and few insureds are in a position to know otherwise), the odds are always against the insured, since insurers must collect more in premiums (often twice as much) than they expect to pay out in losses.

But what of situations where there is no definite limit to the amount of one's possible real loss, as in the case of liability for damages on account of bodily injury to others? There has been much discussion of "safe" limits of insurance, but the only full insurance in this case would be unlimited insurance. It can only be said that, the higher the limits of such insurance, the more nearly adequate the protection.

Personal Insurance. The term "personal insurance" is used to mean insurance used in personal, as distinguished from business or professional, affairs; and also to mean insurance having to do with the "person" as distinguished from property. In the latter category are life insurance and disability insurance.

So far as property, tangible or intangible, is concerned, the basic principles applicable to personal insurance are the same as those applicable to insurance as used in business. But matters of taste and sentiment enter to a much greater degree; concepts of necessities vary greatly between persons. A business firm might consider only efficiency in deciding what its real loss would be; an individual might be influenced by his taste or his desire to please his family.

[7] The insured should consider what he may *collect*. An average, or other, clause in an insurance contract may make it necessary to carry more insurance than the amount of the possible real loss. See pp. 144–149.

He might want to replace an unused old building because it was on his homestead when he was a boy; he might want to repair or replace a large house even after it represented a luxury rather than a necessity.

As to personal insurance in the narrower sense, the principles again apply, but since such insurance is not subject to the limitations of the indemnity concepts[6] it lends itself to less restricted use. And since precise measurement of the possibilities of loss, both financial and emotional, is generally impossible, it is difficult exactly to adjust insurance to needs. One's decision must be based on what one desires, what one's duty is, and what one is willing and able to pay for. The working out of a plan of life and disability insurance is called *programming*, an activity that has developed greatly in recent years. It is so intimately related to other methods of caring for oneself and one's family that it has become part of the broader activity of *estate planning*. As such it may well call for the services of the accountant, the trust officer, and the lawyer, as well as the life- and disability-insurance agent.

It is important for the individual considering insurance to remember that insurance is not something good in itself; that it is a financial tool useful only for the purposes to which it is adapted; that no particular type of contract is, in itself, better than any other; that the best contract is the one that accomplishes as nearly as may be what one desires to accomplish by this means; and that one's ability to maintain an insurance program is limited by one's ability to pay for it.

It may be taken as axiomatic that complete satisfaction by insurance of all one's reasonable financial desires is beyond one's means. But it is well to set down those desires and learn how they might be covered by insurance and at what cost. One needs then to decide what amount may properly be allocated to buying insurance, disregarding the easy rules that seldom fit the particular situation. The ideal program will have to be cut to size in terms both of the importance of the individual items and the money available. For example, one might desire to provide life insurance that, after giving consideration to other reliable resources, would maintain one's widow in the style to which she had become accustomed, see each of three children through college, pay off a mortgage on one's home, and meet the extra expenses incidental to one's death and the reorientation of the family. But the premium for that amount of insurance might be beyond one's means. Presumably the provision for the children, to take one example, would be cut more drastically than the provision for the widow. What might represent discomfort for them might mean suffering for her; they could earn their own way, at least in part, while she might not be able to do so. Or, the demands of duty (if any) satisfied, adjustment might

[6] See pp. 109–114.

be made in terms of personal feeling—less might be done for a disliked member of the family than for one who commanded affection. Solution of these problems is not simple nor subject to formulas.[9]

Disability insurance is basically more important than life insurance. The cutting off of income by disability and the extra expenses incurred because of it may well be more serious than the results of death. For a person without family or other obligations, the case is clear. But even if there is a considerable family, the financial situation is worse if the income producer is permanently disabled than if he dies. He must be maintained and cared for, surely a financial drain and usually requiring time and attention from other members of the family. And disability may defeat the life-insurance program unless it is covered by a waiver-of-premium disability clause in the life-insurance contract.[10]

Difficulties in Applying Principles

These statements of principle may meet objections couched in such terms as "theoretical," "impractical," "unrealistic." If the statements were offered as indications of what a risk manager should be able to do immediately or even over a considerable period, the objections would often be valid. But the statements are intended only as guides, as indications of ends toward which to work where their application is now impossible or impracticable. And, like all general statements, they would be subject to modification in individual cases. The broad point is that the manager should set up guiding principles regardless of immediate possibilities, and regardless of the necessity of trimming his sails to the current situation.

OTHER ASPECTS OF RISK MANAGEMENT

Qualifications of a Risk Manager

Without rehearsing the general qualifications of a person for success in any job—common sense, imagination, persuasiveness, and what not—certain specific qualifications for the job of insurance manager may be cited. The fields in which competence or understanding are most useful are engineering, law, statistics, accounting, finance, mathematics, and of course, insurance.

[9] The reader should try to relate these thoughts to the expected-utility model presented in Chapter 3.

[10] See pp. 325.

Problems of the Risk Manager

Certain problems are found in risk management aside from those of the manager's internal direction of his department. Some of them are reflections of the present state of this particular job; some of them are inherent.

Recognition. One of the problems is that of recognition by executives of the importance of risk management, and the need of high-grade personnel and adequate organization for its conduct. Such recognition is growing, but too many of top management look on the job as one of "buying insurance" and keeping track of insurance policies.[11]

Authority. Authority and responsibility are essential to efficient operation of any department, and risk management is no exception. The manager should be held strictly accountable for results, but he should have the authority to get the results. Too often, he must refer matters of detail administration to superior officers for approval—and too often the decisions in accordance with which he must work are inexpert or even influenced by personal considerations. The manager needs authority not only to deal with outside interests, such as insurers and insurance intermediaries, but authority to set up regulations and secure information within the firm's own organization.

Cooperation. Requiring, as his work does, an intimate knowledge of the entire plant, operations, and projects of the business, the risk manager needs the cooperation of the personnel of all departments in furnishing him with information, in carrying out his regulations, and in discussing with him the risk aspects of their work. All proposed contract forms should go over his desk for consideration—to detect, for example, assumption of liability as part of the contract and to see that it is eliminated or that proper action is taken to meet the risk that it entails. All plans for new construction, new processes, or the use of new material should come to him. He should be thoroughly acquainted with all details of plant and operations. Accidents, regardless of their seeming degree of importance, should be reported to him. All of this he can have only as the result of mutual understanding and of ready cooperation between his department and other departments—and other departments need to realize the importance of the risk problem and the usefulness of risk management.

[11] One form of recognition that is often difficult to get is that implied in appropriation of adequate funds.

Cooperation with the personnel department is of particular importance because the responsibility for employee-benefit plans is often shared with that department.

Recognition of Demand for Insurance. A favorite answer to suggestions for new, and particularly for radically different, methods of insurance is, "There's no demand for it." In addition to the obvious comment that the offering of an improvement normally precedes demand, it is often the case that insurers (and others) fail, perhaps willfully, to hear the demand. Risk managers naturally develop ideas of new ways of dealing with risk, including new ideas on insurance. Part of their job is to find a market for their ideas and to secure the insurance contracts and methods that they seek. Gradually, through discussion and competition, the leading managers are getting insurance more closely adjusted to their needs, and the less able are profiting by these developments. It is only fair to note that insurance intermediaries are often valuable allies in these endeavors.

Knowledge and Theory

Risk management is, if not in its infancy, at most adolescent. Development of the knowledge and the principles essential to bring it to maturity is one of its genuine problems. Risk managers should be able to solve the problem if top management takes the attitude of the writer of the following:[12]

> We encourage our insurance administrator and his key assistants to be active in insurance groups, to serve on insurance committees, and to attend insurance conferences . . . our Insurance Department is in a particularly favorable position to obtain full and complete information on all serious fire and explosion accidents occurring throughout the country. Very often, personal visits are made to the scene of such an occurrence. A thorough examination of the cause of the disaster and the resulting damages, and a study of similar conditions in our own company can develop recommended changes in operating routines, the adoption of appropriate protective devices, or the correction of potential construction deficiencies.

In the past decade several textbooks have been published dealing with risk management[13] and the Insurance Institute of America has established an educational program in risk management.

[12] Liversidge, *op. cit.*, pp. 7, 8.

[13] For example,
Howard, "Cases in Risk Management"
MacDonald, "Corporate Risk Control"
Mehr and Hedges, "Risk Management in the Business Enterprise"
Williams and Heins, "Risk Management and Insurance"

The Future of Risk Management

All signs point to increased recognition and acceptance of the risk manager by management in general, by insurers, and by insurance intermediaries. And the growing importance of risk as an element in business, the emphasis on security, the development of prevention, and the widening use of risk-bearing devices all suggest that risk management will become a major department of business activity. A similar evolution in the affairs of the individual and the family suggests a parallel result in the business of living.[14]

QUESTIONS

1 Why is risk management receiving more attention today than in the past?
2 If you were a risk manager, would you deal direct with insurers, wherever possible, rather than through agents or brokers?
3 Faced with risk, what possible means of meeting it are open to the risk manager?
4 A risk manager dismisses consideration of insurance against a particular type of loss on the ground that "there is practically no chance of its occurring." Comment.
5 It is determined that adopting means of preventing loss will cost more than the saving in insurance premiums resulting from it. Is this fact a sound reason for ruling against it?
6 Walker owns a large house built for the housing of himself, his wife, and five children. The children have grown up and set up households of their own. Walker would be better satisfied with a house that would cost $15,000 to build, though he could collect $25,000 for loss of his present house, if insured for that amount. What amount should he carry?
7 In buying liability insurance, one must decide what limits are to be included in the contract. What considerations would influence your decision?
8 The risk-management function is interrelated with other management functions. Explain.

[14] For an able discussion of the problems of risk management by a risk manager, see Russell B. Gallagher, "Risk Management: New Phase of Cost Control."

5
INSURANCE

In managing the pure risks faced by a business or a family, the risk manager must select the best method or combination of methods for dealing with these risks. Insurance, which is one of the most important methods for handling pure risks, is the major subject of this text. The present chapter describes the basic nature and purpose of insurance and its relationship to gambling and speculation. Chapter 6 presents a summary view of the current mechanism for providing insurance. The remaining two chapters in this part deal with loss prevention and reduction and other methods of handling pure risk.

DEFINITION OF INSURANCE

Insurance has been defined as "that social device for making accumulations to meet uncertain losses . . . which is carried out through the transfer of the risks of many individuals to one person or to a group of persons."[1]

Self-Insurance

If the annual rate of destruction by fire of railroad freight cars has been 3 per 1,000,[2] and if the experience producing this figure covers a sufficiently large number of independent units to be credible, a road owning 200,000 cars might expect, under similar conditions, the destruction of about 600 cars each year from this cause. In some years more would be so lost, in others less, but the average annual loss would be probably about 600 because of the operation of the law of large numbers explained in Chapter 2.

Such a road, if it had a fluctuation fund to absorb irregularities, might

[1] Allan H. Willett, "The Economic Theory of Risk and Insurance," p. 106. The student is urged to read Chapter 7, a classic discussion of insurance and its functions.

[2] This is a purely hypothetical figure.

charge into its operating costs each year the replacement value of 600 cars as lost by fire and transfer the differences between this and the actual losses to or from such fund according to the year's experience. Such handling of a risk is *self-insurance.*[3]

Although self-insurance shares with insurance a reliance upon ability to predict future losses because of a large number of exposure units, it is more properly an example of retention because there is no transfer of the risk to an outside agency. Self-insurance is discussed in more detail in Chapter 8.

Cooperative Risk Carrying

If the railroad had only 1,000 freight cars, the expected annual loss would be but 3, a number much too small to guarantee any appreciable uniformity. If 200 such roads, all having the same average rate of car loss, pooled their interests, and other conditions remained the same after pooling, the total annual loss of the group would presumably be as stable as in the case of the road with 200,000 cars. Some of the roads might lose no cars, and some 10 or more, but over a period of time, the average annual loss would be about 600 cars, and the roads could handle their cost accounts as in the case of the larger road. In this case, the pool would set up the fluctuation fund. The pooling of risks in this way would represent one type of insurance because it involves both a transfer and a combining of risks.

Transfer to Specializing Risk Bearers

Instead of 200 roads, each having 1,000 cars, 2,000 roads, each having but 100 cars, might require protection against unusual annual loss. If, as before, other things were equal, and the risk the same for all, so far as it could be estimated, a pool might be formed with the same result. But, with so many members, the management of the pool would be much more difficult, involving more correspondence, accounting, and other similar work. The roads, however, would find the risk far too great to carry individually, since the expected loss of each would be but 0.3 cars per year, and a single loss might easily be an entire train of 10 or more cars. Upon showing that the average annual rate of loss was 3 per 1,000, some person, or group of persons, might be found willing, in return for an annual payment from each road at a rate a little higher than 0.3 per cent of the value of the cars, to assume the risk and, in

[3] *Self-insurance,* where there is sufficiently broad volume of isolated items to give an average experience and where a fluctuation fund may be maintained, is to be sharply distinguished from *noninsurance,* where these conditions are not present.

the event of loss of any of the cars by fire, to indemnify or reimburse the railroads for the loss; agreeing also that, if the fund so produced exceeded the actual losses and the expenses of operation, the net profit would be retained, and that, if there were a net loss, it would be borne by the person or group by whom the risk was assumed. Such transactions would, of course, be evidenced by written contracts. The arrangement might be proposed by an individual, an *underwriter,* who had set himself up in the general business of issuing such contracts.

Finally, the underwriter might have organized a *corporation* to undertake this work; and the corporation might cover, for varying rates of consideration, risks of loss by fire for many different types of persons and businesses. If charges for such contracts were based on the average rate of loss for each class of risk, with a reasonable allowance for expense and profit, the individuals whose risks were assumed would be in the same position as under the pooling arrangement, though subject to a higher total cost. For them the risk would be eliminated, except that the underwriter or the corporation might fail. The underwriter or his corporation would be subject to the risk of minor accidental variation in the average annual loss, and to the further risk that the losses assumed were underestimated. Against this would be set the chance of unusual profit from a possible overestimate or overcharge. The corporation need not be organized for profit. It could be merely a more formal pooling arrangement with specialized management but with no owners other than the insureds.

INSURANCE AND ITS MAJOR FUNCTION

The last two cases are instances of the transaction of a true insurance business: on the mutual or cooperative basis, in the case of the pool or the nonprofit corporation; on the proprietary basis, in the case of the individual underwriter or profit-seeking corporation.[4]

In the hypothetical cases cited, financial risk has been eliminated, but not loss. *Apparently,* where the risk is covered by the underwriter or corporation, the insured has been saved from loss. In a sense this is true since, if he does sustain loss, he will be reimbursed. Yet, *actually,* if the relation is continued over a long time, he may pay for all his losses, with an added margin for the expense of conducting the insurance business. In order that insurers may pay their losses and continue in business, they must collect an aggregate sum equal to the total of their losses and expenses. So far as society as a

[4] Further discussion of the various types of organization for conducting the business of insurance will be found in Part 3.

whole is concerned, there is not even an apparent elimination of loss. The physical property destroyed can be replaced only by the production of new property through the application of means of production that otherwise might have been employed to produce other beneficial results. It is true that underwriters and insurance corporations make considerable effort to prevent loss, but the cost of this work is met from the funds collected from the public. It is a comparatively modern development.

Insurance in its pure insurance function (ignoring for the moment its efforts at prevention) may be likened to the springs of a vehicle. It absorbs the shock and distributes it over all persons insured in the same class. It permits a freer functioning of credit and industry generally but does not eliminate loss. The retarding effect of risk is removed, but the cost and retarding effect of loss are still present. The burden of loss is still on society. *The pure insurance activity, even though it does not eliminate or prevent loss, is beneficial to society through the elimination of risk for insureds, the reduction of risk in society, and the redistribution of financial loss.* The cost of the insurance is justified by the value of these services alone. It is well to keep attention focused on this fact in order to appreciate fully the principal service of insurance.

When an insured pays a definite premium for insurance, his financial risk is eliminated and a relatively small fixed charge is substituted for the contingency of a large loss. If the amount he pays depends upon the experience of the insurer, he retains some risk but, because of the operation of the law of large numbers, this risk is much smaller than the one associated with loss to his own exposure units.

The risk in society is less because the insureds have transferred their large individual risks to the insurer, whose risk is small because of the large number of units it insures. As a result the economic costs of risk itself (cited in Chapter 1) are reduced. For example, allusion has been made to the extent of the use of credit in modern economic life, and to the fact that risk tends to restrict credit. During the past century the use of credit has become increasingly extensive, and in practically all cases where risk is present and where insurance against that risk may be had, insurance is insisted upon by the lender before credit will be extended. Recent discussion among credit officers of banks has indicated a tendency to place added emphasis on insurance even in the case of current bank credit for commercial enterprises of high credit rating.

Finally, the financial losses that occur will be redistributed in an even load over those subject to the risk. There is a social gain, for, if the incidence of loss upon those who are not prepared for it causes them to fall into a reduced status and to render less worthwhile service or (what is worse) to become community charges, a social loss results.

CHARACTERISTICS OF AN IDEAL INSURABLE RISK

Some characteristics of an "ideal" insurable risk have been implied at several points in earlier chapters, but it is instructive to group these characteristics together and to add to the list.

First, there should be a large number of insured units independently exposed to the potential loss covered by the insurance. This condition must be satisfied for the law of large numbers to operate effectively. Although there may be a large number of units exposed to this loss, they will not be insured (1) if the potential loss is so small that it is of little concern, (2) if the probability of loss is so small that most persons believe (perhaps mistakenly) that they can safely ignore it, or (3) if the probability of loss is so high that the premium appears too high relative to the loss.

Second, the loss should be definite as to cause, time, place, and amount. Otherwise it is difficult to adjust losses and to accumulate meaningful loss experience.

Third, the expected losses should be calculable in order to establish the insurance premiums. The first and second conditions must be satisfied for this to be true. Changes over time in the underlying cause system should also be small or fairly predictable.

Fourth, the loss should be accidental from the viewpoint of the insured.

No risk is an ideally insurable risk. Fire losses to dwellings approach this ideal, but insurers must take special steps (see Chapter 30) to avoid catastrophe losses, the amount of the loss is frequently a subject of debate, and some unscrupulous persons do collect from insurers who cannot prove that their fire losses were intentional. Sickness losses are difficult to verify, but health insurance has expanded phenomenally since the Second World War. When a new type of insurance is written, an insurer must usually experiment for several years to determine the appropriate premium rates.

Slight departures from the ideal do not unduly concern the practical insurer. If the departure is great, a private insurer may still provide protection against this risk because it will help sell other types of insurance, because the insurer believes that it is obligated to underwrite this risk, because it predicts that this risk will become insurable later, because it wishes to forestall governmental activity in this area, or for some other compelling reason. A government insurer may be able to underwrite risks that a private insurer would reject because it can make the insurance compulsory and because it can vary the premium rates over time for the covered group as its needs dictate. Unemployment insurance is an example of such an activity.

It should be noted that insurers vary in their willingness to underwrite many risks and that insurers as a group have over time expanded greatly their concept of what is insurable.

INSURANCE VS. GAMBLING

The transaction by which risk is transferred from the individual to the underwriter resembles in many respects a bet and is often referred to as such. It is said, for example, that the householder bets $80 that his house will burn within a 3-year period against the insurer's wager of $12,000 that it will not. The resemblance, when the transaction is stated in this form, cannot be denied.

Gambling

A bet on the way a coin will fall, or on the result of a horse race, will be readily recognized as gambling. Before the bet is laid, the fortune of neither of the bettors can be influenced by the uncertain future event. Neither is subject to a risk on account of it. After the bet has been made, each is subject to a risk of loss—though more thought is usually given to the possible gain. By the transaction a speculative risk was created for each. A bet at a gambling table at the Casino at Monte Carlo or Deauville is made under different conditions. The gambling house is daily handling large numbers of such transactions and is subject to no appreciable risk since its operations are based on the law of large numbers. Each new bet merely adds one more to the number of transactions, tending further to reduce the small margin of risk due to slight irregularities in the way the transactions turn out. Although this is true as to the "house," it is not true as to the man who made the bet. He was subject to no risk before he bet. The bet created the risk. An examination of any number of gambling transactions would reveal the same condition. The essence of the transaction that makes it gambling is the creation of a risk,[5] either for the thrill it may give or because it is estimated that the chance of gain exceeds that of loss. Since risk of this sort is inimical to economic progress, gambling is antisocial.[6] In general, in the United States, gambling contracts are not enforceable, and gambling is generally illegal.

The gambling contract might be in the form of an insurance transaction, if one took out a policy of fire insurance on property in which one had no financial interest, or a policy of life insurance on the life of another whose death would not in any way cause one loss. There is a double reason for prohibiting such contracts; they not only create unnecessary risk, but also

[5] A risk is sometimes created as a necessary condition of social service, as when one builds a house and creates the risk of loss by its destruction by fire. But the creation of risk in this case was incidental and not the purpose of the action. It is not gambling.

[6] To the extent that gambling furnishes amusement considered by its participants to be worth the cost, this statement might be qualified.

tempt to the crimes of arson and murder. Such life-insurance contracts were at one time permitted and enforceable in England, but recognition of their true nature and dangerous character caused them to be prohibited in the eighteenth century.

Insurance the Reverse of Gambling. The insurance contract accomplishes exactly the reverse of the gambling transaction. Prior to its negotiation the individual is subject to the pure risk insured against. After its issuance he is not. The insurer, by combining the risk assumed with that of many others, destroys it as risk, a certainty or near certainty resulting. This is a high social service, and the activities of insurers are promoted and safeguarded by wise public policy.

Speculation

Underwriters have sometimes taken risks of which too few existed to assure stable results. As an example may be cited agreements to indemnify in large amounts famous violinists for loss due to injury to fingers. It is commonly understood that there are underwriters at Lloyd's, London, who are willing to issue policies insuring against almost any type of risk, however singular or spectacular, be it only a real risk. This is spoken of popularly, often with ridicule and contempt, as being mere gambling; but according to the foregoing analysis and definition of gambling such practices are not properly so described. There is no creation of risk. Violinists of first rank are exposed to risk of very large loss from injury to their fingers. Neither does it apparently come within the definition of insurance, since the risks are too few in number for any underwriter to get a volume sufficient to give a reasonable average, i.e., to permit the practical operation of the law of large numbers. The qualification should be noted that underwriters covering such risks usually cover a large number of risks of varying types, though each may be unusual or even unique. In such a business there is often found a stability in the mass that resembles in greater or lesser degree that developed from a large number of like risks, but, even though there were not this limited application of the insurance principle, the case would be quite different from the gambling transaction. It is a transfer of already existing risks, not the creation of new risk.

Though no elimination of risk may take place, this transfer is not inimical to social welfare unless it is from stronger to weaker shoulders, or promotes such indifference to loss as to increase the actual losses occurring. Usually the transfer is from the weaker to the stronger. Those assuming the risk divide it among themselves so that they are in a better position to stand it

than he who was originally subject to it. Among insurance men such transactions are known as *speculative transactions* or *speculative insurance*, or more briefly, *speculation*. It will be apparent that there is considerable resemblance to those transactions in the commodity markets usually called "speculative." *Speculation*, when used in connection with insurance, may be defined as the transfer of risk without amalgamation and without redistribution. Such transactions do not perform the social service of insurance—the elimination of risk. The incidence of the actual losses that occur is still haphazard. The social gain, if any, is the transfer from one less able to stand the shock to one more able.

If it is not known, when a new type of risk is offered for insurance, what is likely to be the average value of the risk; and if its probable volume at the outset is limited, the underwriting of such insurance is speculative. For example, rain insurance—the insurance of the proprietors of outdoor exhibitions against loss due to untimely rain—was begun in a very tentative way. Although, in the records of the Weather Bureau, there were data from which the risk could be estimated, the volume of insurance that could be obtained was felt to be too limited to develop average conditions. Now, with the data to estimate risk and the experience of a past volume of business to serve as a guide in other respects, it has passed from the speculative type to the true insurance type of transaction.

If, in the speculative transaction, the risk tends, after transfer, to be greater than before, the transaction tends toward gambling, and is antisocial because it imposes an additional impediment to economic advance.

QUESTIONS

1 In what ways does the transfer of risk to a pool differ from a transfer to specializing risk bearers?
2 Why is an insured often willing to pay more than his expected loss for insurance protection?
3 How does society gain from the existence of the insurance institution?
4 In what ways does an insurance contract resemble a wager? What are the differences between these two contracts?
5 Is death an ideally insurable risk? Explain.
6 Is speculative insurance insurance? Is it gambling?

6
THE INSURANCE MECHANISM

The preceding chapter dealt with the theory of insurance. The present chapter has to do with the mechanism of insurance—its component parts and their interrelations. While, broadly speaking, the same theory underlies the operation of all types of insurance, and the same general mechanism is used to implement the theory, there is the utmost variation in practice.

CLASSES OF INSURANCE

Life insurance—insurance against loss due to the contingencies of living or dying (*life contingencies*)—constitutes one broad class of insurance; insurance *other than life,* the other. Between these two classes certain broad distinctions may be drawn; within them are further classes, distinguished one from the other by increasingly fine distinctions as they are broken down, until one becomes more impressed by the diversity than by the unity of the insurance institution.

Insurance other than life has traditionally been classified as *fire, marine,* and *casualty,* but increasingly this insurance is considered to be health insurance, property insurance, or liability insurance. Fire insurance is insurance against loss caused by hostile fire[1] and, in practice, carries with it insurance against loss by lightning. Traditionally, fire insurance also includes certain *allied lines,* insuring against loss by such causes as wind, hail, rain, collision, riot and civil commotion, explosion, water damage, and earthquake. Marine insurance covers principally losses due to the perils of transportation. Casualty insurance protects insureds against a wide variety of causes of loss, principally liability under the law of negligence and under workmen's compensation acts, but it also includes many other kinds of insurance such as health; glass; boiler and machinery; burglary, theft, and robbery; and surety bonds.

[1] See p. 160.

Under the newer terminology *health insurance* covers losses caused by poor health; *property insurance* covers losses to the insured's own property or property in which he has some financial interest; and *liability insurance* covers liability for losses to the person or property of others caused by the insured.

Life insurers write life and health insurance. Multiple-line insurers write all lines other than life. Some insurers still prefer to emphasize fire insurance, marine insurance, or casualty insurance.

INSURANCE LANGUAGE

The student should beware the pitfalls of insurance language, both official and colloquial. The same word may have different meanings in connection with different types of insurance, and the same thing may be described by different words. Words having commonly accepted meanings elsewhere may have other meanings in insurance, and insurance words are often used loosely, even by insurance men. In this text it is intended to make clear the meaning of terms necessary to an understanding of the subjects discussed.[2] Occasionally the authors will use their own terminology, but mostly the usage will be that of the insurance community.

WHAT IS INSURANCE?

For the practical purpose of presenting the mechanism that gives effect to insurance, it may be said that *insurance* is a promise by an *insurer* to an *insured* of *protection* and/or *service*.[3] By "protection" is meant making good financial loss; and by "service," rendering aid of various sorts in connection with the promise of protection. The promise is made only to the extent that the loss may be caused by fortuitous events, and, with certain exceptions,[4] promised protection is legally enforceable only to the extent of actual loss. The insurer is the person or organization making the promise, the insured the person or organization subject to loss to whom it is made.

As a single example, consider an owner of a motor vehicle. He is subject to the risk of claims for damages alleging injury to persons or property; he is also subject to the danger of damage to, or destruction of, his car. He, as insured, may arrange with an insurer that the latter will, within limits, make

[2] For further information see Clyde J. Crobaugh, "Handbook of Insurance," and Ralph H. Blanchard (ed.), "Dictionary of Insurance Terms." The Commission on Insurance Terminology of the American Risk and Insurance Association has considered the preparation of a dictionary based on extensive discussions by insurance practitioners and academicians.

[3] For discussion of legal definition of insurance, see p. 540.

[4] See pp. 126–128.

good any financial loss due to these causes and also serve him in investigating accidents, negotiating settlements, and defending suits.

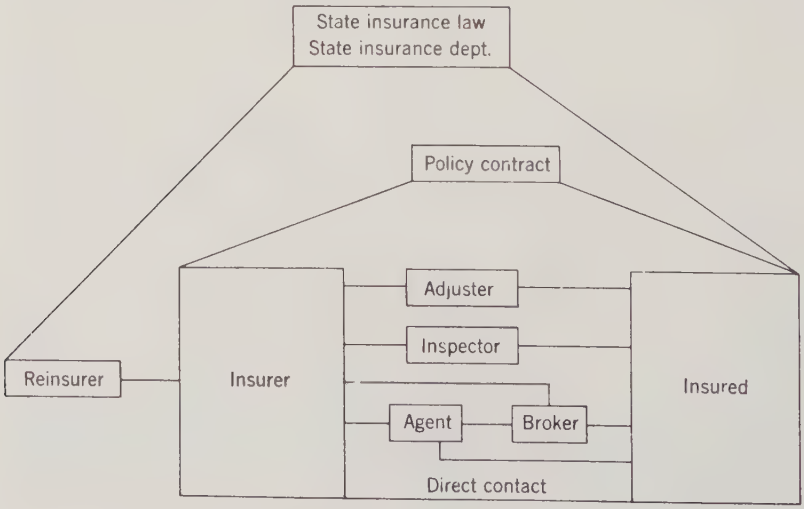
THE INSURANCE MECHANISM

As a basis for detailed discussion of the various facets of insurance in later chapters, there will here be presented an outline of the mechanism of insurance. It will include certain necessary definitions of basic terms, and indication of the functions and interrelations of the component parts of the mechanism, but no attempt will be made to achieve completeness or to draw fine distinctions.[5] Each of the broad subjects here explained briefly will, in later chapters, be broken down and discussed in detail; the purpose of this chapter is to present the background into which each subject fits and to prepare the reader to understand the general relationship of each subject to the whole. Before studying any specialized chapter or group of chapters, it is suggested that the diagram below be reviewed.

Contact

The first essential to making a contract is contact between the parties, direct or by representative.

[5] The internal organization of insurers, insureds, and other parts of the mechanism will be considered elsewhere.



The Insurance Mechanism

Direct Contact. The simplest form of contact is direct meeting of insurer and insured, but it is the least practiced. Under the head of "direct" come meetings effected by mail, by the insured calling at the office of the insurer, or by a salaried employee of the insurer calling on the insured. Often a first meeting is effected by a personal call, and the relationship continued by mail; in some cases other combinations of these several methods are used; in others mail is the only means of contact. Insurers using any of these means are *direct-writing* insurers. Occasionally a direct-writing insurer combines representation by intermediaries with direct contact.

Intermediaries. By far the greater part of insurance is negotiated through intermediaries, and the *agent* is the usual intermediary between insurer and insured. The insurance agent is the agent of the insurer. While acting as such, and within the scope of his apparent authority,[6] his acts, omissions, and knowledge are those of the insurer. His authority, his rights, and his obligations are defined by the *agency contract* with the insurer and by law. He may be authorized to make insurance contracts; or he may negotiate with the insured, subject to final action by the insurer. In general, it is his function to induce the insured to buy insurance, to assist the insured in planning his insurance program, and to serve as a continuing means of communication between the parties to the policy contract. The insurer pays him *commissions*, usually a percentage of the premiums on the insurance effected through him, but sometimes a fixed fee, and in some cases also bearing a relation to the quality of the insurance in terms of its profitableness to the insurer or other characteristics. The agent operates his agency as an independent businessman, with or without staff as the nature and extent of his business dictate.

The insurance *broker* is the representative (in general parlance, the "agent") of the insured. It is his function to advise the insured and to negotiate insurance contracts for him on the most advantageous terms with the insurers best suited to serve him. He has no contract, though he may have an account, with the insurer and is paid by commissions which he ordinarily deducts from the premium transmitted by him from the insured to the insurer. His rate of commission is regularly somewhat less than that of the agent. He may place insurance direct with the insurer or through an agent of the insurer. If the insurance is placed through an agent the latter's remuneration is the difference between the commissions at the two rates. Brokers operate principally in certain of the larger cities and are not recognized under the laws of certain states. While they may place insurance for anyone, they are particularly concerned with insureds having extensive interests. While the

[6] See p. 396.

broker is primarily the representative of the insured, he may, under the laws of certain states, be the representative of the insurer for the collection of the premium or the delivery of the policy.[7]

An individual (or organization) may be an agent for certain insurers with which he has agency contracts and, at the same time, be authorized to act as a broker, in which case he is a *broker-agent.* He may not, however, act in both capacities in the same insurance transaction.[8] It is ordinarily to his interest to place insurance with the insurers with which he has agency contracts, but he may find it necessary to deal with other insurers. A risk may be unacceptable to any of his principals; it may be beyond their capacity to insure; or the insured may direct him to place the risk with an insurer for which he is not an agent.

The Inspector

The function of the *inspector* is a universal part of the insurance mechanism, but the manner of his performance and the title of the functionary vary between classes of insurance. Here it is necessary only to indicate that the insurer needs, by some means, and to some extent, to have knowledge concerning the insured and the subject of the insurance. In life insurance they are the same; in most kinds of insurance they are a person (or organization) and a thing. Inspection determines the acceptability of a proposal for insurance, the price, and the terms of the policy contract. It may be the detailed and intimate examination by a physician and the probing of a special investigator into the habits and other activities of an applicant for a large amount of life insurance. Or it may be the classification by an insurers' organization of a small frame house in a rural environment as one of many of the same type that will be covered for small amounts of insurance and that can be treated en masse.

By whatever name he goes, inspector, medical examiner, rater, or credit man, his function must be performed. His importance anad method depend on the kind of insurance and the circumstances of the individual case.

The Adjuster

The *adjuster* serves in the settlement of claims against insurers. His function, therefore, needs to be performed when a claim is made or where the possibility of a claim demands action to ward it off or to prepare for it. The difficulty

[7] See pp. 404–405.

[8] Except with the agreement of both parties, for which, practically, there would be no reason.

and complexity of his assignment vary greatly between classes of insurance and individual claims. Very little difficulty is attached to settling a claim for $1,000 under a life-insurance contract if the insured and payee are clearly identified and death took place while the insured was under the care of a physician in his home where he had lived for years. In contrast, consider a claim for loss of $500,000 in profits and continuing expenses due to fire, in a period of decreasing business activity, by a corporation manufacturing a commodity subject to highly elastic demand, and under insurance with several insurers whose contracts expired one hour after the asserted time of origin of the fire.

The adjuster's prime object should be so to settle claims that the obligation of the insurer, as expressed in the policy contract, is met. But he should also seek to do what he reasonably can to leave insureds and the public generally with a favorable impression of insurance. He should strike a balance between protecting the interest of the insurer and satisfying insureds and claimants. And incidentally he should help the insurer in acquiring knowledge of risks at the point where hazards are most vividly and accurately exemplified.

The specializing adjuster is a representative of the insurer, though, to some extent, *public adjusters* represent insureds. And it should be noted that the adjusting function may be performed by persons not labeled "adjusters." An insured may be represented by his lawyer or his broker. The insurer may, particularly in the case of small claims, authorize an agent, an employee not designated as an adjuster, or a lawyer to represent it, either to conduct the adjustment up to a specified point or to make final settlement. The insurance agent is, in effect, though not technically, more often the representative of the insured than of the insurer.

The Contract

The basic rights and obligations of the parties to the insurance agreement are stated in the insurance contract, and the activities and relations of the parts of the insurance mechanism that have been explained, flow out of those rights and obligations. It is an essential part of the mechanism in every case.

Insurance contracts tend to be highly standardized—by statute, administrative control, agreement among insurers, or custom. Much the same fire-insurance contract is in use in all jurisdictions; in most, the basic form is required to be used by regulation or by statute. The basic form may be adapted to particular cases by endorsements, many of which are themselves in considerable degree standardized. Life-insurance contracts and health-insurance contracts are required to contain certain standard provisions; aside from these provisions competition and agreement have produced a high degree of standardization. In other fields of insurance, standardization is usually

voluntary and incomplete. In recent years, as price competition has become more intense, there has been less voluntary standardization in certain mass-marketed contracts such as automobile insurance, but the differences among the nonstandard policies are usually such that a knowledge of one contract has much transfer value in understanding the other contracts.

But if one turns to the contract for a complete statement or explanation of the relations, rights, and obligations of the parties one will be disappointed. For the contract is what it means, and what it means is determined by custom, negotiation, court interpretation, and statutes. The contract may require the insured to submit a detailed inventory of property damaged or destroyed, but, in certain types of loss, the requirement may customarily not be enforced. Negotiation may lead the insured to accept a compromise settlement of a claim of doubtful validity, or lead the insurer to pay where technically it is not liable. The court may say that knowledge of the loss acquired otherwise by the insurer excuses the insured's failure to give notice. And a statute may provide that, although the contract requires the insured to file a form of proof of loss on his own initiative, the insurer, if it requires such proof, must demand it and furnish a blank form for filing it.

Reinsurance

Insurers often find it necessary or at least advantageous to *reinsure*, in whole or in part, risks that they insure. The reasons for reinsurance are various and will be dealt with elsewhere. It is sufficient here to note that *reinsurance* is a device for the protection of the original insurer, both in special cases and as a routine part of coping with the problems of insuring the public. The insured's contractual relationship is wholly with the original insurer—his only interest in reinsurance is in its function of contributing to the strength of the insurer by taking over a part of its burden of risk.

Reinsurance is written under contracts largely standardized by custom, and to some small extent by agreement and governmental regulation, but subject to negotiation between reinsurer and reinsured. Insurers may also write reinsurance, and there are many specializing reinsurers who write only reinsurance. Much reinsurance is placed abroad with alien reinsurers, particularly with the underwriters at Lloyd's, London.

Governmental Regulation

While the federal government has the power, under the commerce clause of the Constitution of the United States, to regulate most insurance activities, Congress has not seen fit to exercise that power. It rests almost entirely with

the several states, the possessions, and the District of Columbia,[9] though Congress may change the situation by broadening the scope of federal regulation.[10]

Each state has enacted insurance regulatory laws and has assigned to a state official, or official body, the administration of the laws. The official is usually called the *insurance commissioner,* though formal titles vary. The group of persons concerned with the administration of the law—the commissioner and his subordinates—constitute the *insurance department.*

The general purpose of governmental regulation of insurance is to protect insureds and, to some extent, third parties for whose benefit insurance is written. Its principal and most important aim is to require insurers to maintain their solvency, on which rests their ability to perform the promises made in insurance contracts. Secondary to this aim, but likewise of great importance, is the regulation of practices of insurers and other parts of the insurance mechanism to the end that they deal equitably with the public. A third aim that is relatively new and undeveloped is competence of personnel, particularly of agents, brokers, and adjusters.

QUESTIONS

Because the purpose of this chapter was to provide a bird's-eye view of what lies ahead, no review questions are provided. However, the reader might profitably summarize in his own words the components of the insurance mechanism and their major functions.

[9] Hereafter the term "state" or "states" will be used to include the other jurisdictions.

[10] See Chapter 34.

7
PREVENTION OF LOSS

The cost of risk, although real, is of a secondary sort. It arises largely from the psychological effect upon human action of possibility of loss, and of uncertainty whether it will befall the individual. In addition to this burden, society must bear the undiminished burden of actual loss. This chapter deals with loss-prevention-and-reduction measures—the only method of handling pure risk that reduces the actual losses in society.

Prevention More Desirable than Insurance

Even when the risk cost is eliminated by insurance, the cost of conducting the insurance business (and this is not negligible by any means) is added to the loss. Therefore, though a particular type of loss cannot be wholly prevented, there will be social gain if it can be reduced because of the reduction of the loss and the reduction in the cost of the insurance service, which tends to increase roughly in proportion to the expected loss. These propositions are axiomatic, but they are generally overlooked or forgotten. "I am insured. I should worry!" is all too often the public attitude, and if, after reading the account of a disaster, one reads the trite fallacy, "Loss fully covered by insurance," one sinks back into complacent satisfaction with the workings of the economic organization and passes to the next item.

American Indifference to Prevention

This is notably an American attitude. In a country of vast resources only partly tapped, it is natural for people to try to use what they have to the utmost and rush ahead to get more, rather than "waste" precious time in the slower process of saving and trying to add a little to the accumulated store. It is, of course, true that all manufacturing consists of the destruction of certain things in order to change the form of the materials of which they are

made into more useful things. Thus, fuel is burned and iron ore smelted to make steel; trees are cut down and sawed up to make lumber; other materials are used to make glass. Out of these products houses are built and other useful things are made. Our purpose would have been defeated and our advance retarded if these processes had been interfered with or prevented.

Gain from Prevention

There is a vast difference between this destruction of raw materials as such, and allowing the house to stand without paint until it rots away under the wear of the elements. The destruction of the raw material in the first case was not a loss but a gain, for out of the destruction came something more useful. In the second case there was real loss. As long as the cost in labor and material of safeguarding what one has is less than the cost of replacement multiplied by the probability of loss without such safeguarding or, in other words, as long as the aggregate annual cost to all individuals of prevention is less than the average aggregate loss prevented, clearly there is social gain in prevention.

The practical application of the general principles of preventive and protective effort to each of the fields where loss may occur is a problem related to that field. Discussion of such specific problems in detail will not be attempted, but an endeavor will be made to give a sufficient number of illustrations to make clear the meaning of the general principles discussed and to show the relation of the specific problems to insurance.

TYPES OF PREVENTIVE AND PROTECTIVE EFFORT

Preventive and protective efforts fall into four classes:

1 *Preventive,* the purpose of which is to eliminate the causes of loss. In the case of physical property it is most effectively applied in the planning and construction of the house, machine, or other property. In the case of injuries to persons, psychological factors may be involved.
2 *Protective* or *quasi-preventive,* the purpose of which is to protect things or persons subject to damage.
3 *Minimizing,* the purpose of which is to limit loss to as small a compass as possible.
4 *Salvaging,* the purpose of which is to preserve as much as possible of the value of damaged property, or of the ability of injured persons.

The world not being in a series of compartments but a continuous whole, there is some overlapping of classification, so that some efforts fall into two

or more classes, but, generally, the types may be distinguished. Each of these classes may be considered from the point of view of its effectiveness, its agencies, and its promotion.

Pure Prevention

Preventive efforts of a fundamental or structural sort are the most effective. A fire-resistive building[1] is least likely to be damaged, and is almost immune to destruction, by fire. A machine with nonremovable guards that make it impossible for a person to come in contact with moving parts cannot injure its operator. It may often be beyond the limits of practicable efforts to go so far. Much, however, may be done to prevent loss by proper structural safeguards. European cities, built largely of brick and stone, have a much lower fire-loss record than American cities. Certain cities in this country have had enviable records because of superior construction. Much reduction in industrial accidents has resulted from improved machine building under the influence of the safety movement following the passage of workmen's compensation laws. Many devices, the predecessors of which in the factory were regarded as most hazardous, e.g., power ironing machines and centrifugal extractors, are now safely used in homes. Probably the most striking example of true preventive effort is the elimination of the yellow-fever menace in the Canal Zone and the Gulf states by mosquito control.

The beginning of such efforts must be in community sentiment, e.g., a demand for an adequate building code and its enforcement. Such a code should deal with materials, design, and equipment.[2] Likewise an adequate and enforced safety law is the beginning of industrial safety in machine design. Suitable sanitary codes are essential in the prevention of loss due to sickness. The same principle applies to all fields.

Perils and hazards change with the progress of science and invention, and such codes, to be effective, must be kept up to date.[3] Since legislative machinery is usually cumbersome and slow moving, some communities have passed general statutes providing for such codes and have delegated to special commissions, employing competent engineering and other assistance, the

[1] There is no completely fireproof building, i.e., one that cannot be damaged by fire.

[2] A model building code was prepared by the National Board of Fire Underwriters (now part of the American Insurance Association) in 1905. It has been revised from time to time to keep it in line with advances in the art of building. A standing committee is charged with constant study of the subject.

[3] The hazards due to the use of nuclear energy are the subject of new laws and regulations.

framing and correcting of the specific codes.[4] The prime essential in this respect, however, is an aroused public sentiment in favor of safe conditions and, consequently, of a good code and its enforcement. Even better is the ingrained habit of safety as with the inhabitants of European cities. This is not the usual heritage of our conglomerate American city populations. Of course, the code of itself is not preventive. It is construction in accordance with the code, and the efforts of individuals to surpass the code, that bring progress.

Protection

Protection is less effective than pure prevention and is not a substitute for it; but, if property is subject to loss, protective effort is in order up to the limit of practicable cost. Protective efforts against certain types of risk are undertaken at large cost by all communities, yet, even in regard to these types, there is opportunity for the individual owner to supplement the community effort. In other types of risk the matter rests largely with the individual. The most conspicuous protective efforts are the maintenance of police departments for protection against loss due to crime and to vehicular traffic. Elevator and steam-boiler inspection is undertaken by the governments of most of the states, though the inspection of authorized insurance companies is usually accepted in lieu of public inspection. The purpose of inspection is to see that conditions likely to cause loss are not present. Safety inspection of factories is undertaken by both states and insurers with a view to eliminating causes of loss due to weakened structural conditions or other substandard conditions in buildings and equipment, or to hazardous processes and unsafe practice. This is pure preventive work, but it takes on also the character of protective work, since it results, when structural conditions cannot be changed, in the requirement of protective measures. Periodic watchman service, especially if checked with a recording clock, is a safeguard against loss by theft, fire, and other causes, such as water leakage. The latter efforts, however, partake also of the nature of the third class: minimization. One of the most potent efforts in the protective class is the campaign of education in "safety first" applicable to all types of risk, leading as it does to the discovery of weak points before they give way. A suitable allowance in the premium rate for the effect of these efforts tends to stimulate them and turn them into the most productive channels. This allowance is only equitable since, if the function of

[4] In New York, for example, the Board of Standards and Appeals is charged with framing the Industrial Code, and the Industrial Commissioner with enforcing it.

insurance is to combine risks and distribute the loss of the mass over the individuals, each individual should be charged only in the proportion that he tends to contribute to loss. In certain European cities the citizen on whose premises a fire originates is held liable to the city for the cost of calling out its fire fighters, and to his neighbors for damage to their property unless he can prove the fire was unpreventable.[5]

Minimizing Loss

Probably more community effort and money are expended in seeking to minimize loss than in any other direction. For under this head falls the maintenance of fire departments, of water supplies for fire fighting, and of other emergency equipment and organizations. Such efforts are necessary, but a much smaller fire department can effectively serve a city in which frame exteriors and shingle roofs do not exist than one where the major part of the construction is of that type. A much smaller expenditure is required for medical service when water and milk are properly inspected and safeguarded against infection than when such work is not done. It has been found much more effective in military organizations to inoculate against typhoid fever and similar causes of disability than to rely entirely on hospital facilities and quarantine for those who may become infected. Efforts to minimize loss are not to be neglected, but the need of such efforts will be much reduced by effective measures for pure prevention and protection.

Probably no device for minimizing loss is more important than the automatic sprinkler systems now so widely used in manufacturing and mercantile establishments as a protection against fire. These systems consist of overhead water piping with valves spaced at about 10-foot intervals. The valves are kept closed by a lever held in place by fusible material and are faced by a small baffle plate. When opened they throw a spray over a circle about 8 feet in diameter. Excessive heat will release the lever and open the valve, usually extinguishing the incipient blaze or at least holding it in check until the arrival of firemen. An alarm is usually coupled with the system to call the fire department or a watchman for, if this were not done, the water damage might exceed the fire damage, or the fire might get beyond control.

Fighting fire involves more or less water damage to goods, even if they are not directly damaged by fire. Consequently, public fire departments have

[5] It is a long-standing rule of the law of this country that one must respond in damages for the consequences of negligent actions. Technical defenses as well as insurance against judgments on account of such neglect have, however, lessened the fear of consequences so that the preventive value of the rule is somewhat doubtful.

increasingly assumed responsibility for spreading waterproof coverings over goods and otherwise preventing further loss.[6]

Salvage

Salvage operations are profitable if the salvaged property represents a value greater than their cost. Salvage operations are seldom conducted by community efforts, though the police recover much stolen loot. Another type of salvage operation frequently carried on by special organizations is the reconditioning for sale of smoke- or water-damaged goods. Similar in nature and result are rehabilitation efforts in behalf of workers injured in the course of their employment and entitled to benefits under workmen's compensation acts. Employers or their representatives are prompted to offer such claimants the best type of rehabilitation treatment because it will reduce the cost of the compensation they are required to pay. But the victims of industrial accidents and the community profit much more than employers by their restoration to earning power. These rehabilitation efforts are and should be extended to benefit the victims of automobile and other accidents.

Salvage operations, however, are but a negative sort of preventive effort. Far more importance must be attached to positive efforts of prevention and protection.

Other Classifications of Preventive and Protective Effort

Preventive and protective efforts can also be classified according to whether they emphasize (1) the engineering approach or (2) the human-relations approach. The engineering approach emphasizes the correction of mechanical causes such as defective construction. The human approach seeks to improve human attitudes and skills. Although both approaches are applicable in most situations, the engineering approach is emphasized in the prevention of fire losses and the human approach in the prevention of industrial and automobile accidents.[7]

Preventive and protective efforts can also be classified according to who is responsible for initiating or maintaining the effort—individuals, businesses, trade associations, special private safety groups, or the government (federal, state, or local).

[6] Until recently this work was performed by special fire patrols maintained by insurers on a voluntary or compulsory basis.

[7] However, recent writings by Ralph Nader and recent hearings before Congress have stressed the importance of building safety features into automobiles.

INSURERS AND PREVENTION

To solve the problem of fixing a proper rate for each risk presented for insurance, underwriters must study the causes of loss and the relative effectiveness of means of reducing them. They have come to be looked upon as experts and leaders of the community in prevention. But until comparatively recently they had not fully realized and responded to their high opportunities. As early as 1764 the underwriters at Lloyd's, London, had compiled and issued for their own use "books" (the precursors of the modern shipping registers) expressing their opinion of the hazard value of existing shipping. These were carefully guarded by their owners, however, and there appears to have been no effort to improve shipping or shipbuilding.

The first recorded efforts at prevention or protection by the insurance business were made by the first joint-stock and mutual fire-insurance companies formed in London after the great fire of 1666. Since, with fixed premiums, whatever salvage was made went to the profits of the companies, their managers early saw the value of preventive efforts. These insurers organized and maintained uniformed private companies of fire fighters and equipped them with such simple devices as were available in that day. The insurers also devised markers or house plates to identify the houses insured by them. When not engaged in putting out a fire in an insured house or in salvaging the contents, the firemen were free. It is said that often, on observing a fire, they would run to the house and, if they found it was not insured by the company by which they were employed, they would bargain with the owner for the best reward he would pay for their aid. House plates and private fire brigades were also used in earlier days in the United States.

In the early part of the last century, the attitude of insurance executives was that it was their business only to measure hazards and collect premiums to cover losses. It was the owner's duty to prevent them. Thus, when the owner of a textile mill in Providence sought advice on preventive measures, he was rebuffed. This lack of interest on the part of the established insurers, together with their unwillingness to cover certain parts of the mills, and their crude rating system, which did not allow credit for preventive efforts, led to the formation of mutual companies among the mill owners for insuring their premises and specializing in prevention. The competition so developed opened the eyes of the executives to the error of this policy, and their attitude has since completely changed.

Property and Liability Insurance

In the present day, the leaders in preventive effort in all lines are the insurers. The knowledge acquired in investigating losses and their causes equips them to be leaders in such work. In fact, they have gone much further and have

promoted research to develop new standards and better practice. Lloyd's and the various organizations of marine underwriters in different countries have representatives in the leading shipbuilding centers and world ports for the supervision of construction and repair of ships. They have developed most efficient marine intelligence offices and have been instrumental in the passage of legislation for proper loading limits and other safeguards.

Among the primary functions of the American Insurance Association are the prevention of arson and the development of fire prevention and protection, the development and updating of a model building code, and sponsorship of the Underwriters Laboratories, which makes it its business to test in the laboratory fire-resisting and fire-controlling materials and devices, and the fire hazards of various processes. Devices and materials tested by it and manufactured under its specifications are permitted to carry labels certifying to the classification in accordance with the laboratory findings. The Laboratories have also undertaken similar tests of machine design and safety devices. Mutual insurers not affiliated with the Association have similar laboratories, and there are several organizations in different countries of the world for inspecting and certifying ships.

Of great significance is the work of the Association's engineers in surveying and grading the towns and cities of the United States from the point of view of their fire hazards and protection against them, including, among other things, water supply, building construction, street arrangement, and fire and police departments. Although these investigations form the basis for establishing insurance rates, recommendations for improvements are also embodied in such reports.

If efforts along these lines are effective and loss cost is reduced, the result is reflected in reduced insurance cost. By adjusting premium rates to the loss-preventive effect of structural conditions and of other preventive effort, insurers encourage better conditions and, to the extent that such adjustment is accurate, direct effort and expenditure into the most effective channels.

Reformation from without is always difficult and distasteful. The most effective work must be by education so that the desire comes from the public. The Association has, therefore, encouraged in every way the work of the National Fire Protection Association, which is composed of public officials and others interested in the prevention and control of fires, and is organized for the purpose of furthering such work.

The Factory Insurance Association maintains an inspection service and laboratories for the study of hazards and production, as do the Factory Mutual Insurance Companies and certain other mutuals. With the adoption of workmen's compensation laws, which specify benefits and make rates for the required insurance subject to state regulation, insurance competition in this field has centered in no small degree upon service to the insured employer. Insurance rates are modified in accordance with the losses experienced on

individual risks and the general level of rates is affected by general improvement in control of hazards. Insurers make safety recommendations and vie with each other in the services they offer, as do some of the larger agencies and brokerage firms. Some insurers have been leaders in the rehabilitation efforts noted earlier. One of the most frequently cited works on industrial accidents was written for a major insurer by a safety engineer, H. W. Heinrich. Heinrich observed that unsafe acts of persons, not mechanical causes, were responsible for 88 per cent of the industrial injuries involving personal injuries to workmen. He also argued that it was a mistake to concentrate attention on those accidents that cause serious injuries because the severity of an accident is largely a matter of chance. Finally he emphasized that employers had good reason to be interested in safety because the uninsured costs of an industrial accident greatly exceed the insured costs.[6]

The frequency of automobile accidents and the resultant problems have led to increased activity in engineering, police, and educational efforts to prevent them and to minimize their effects. For example, the American Insurance Association through various publications and personal contacts with public officials and citizen groups has urged each community to obtain an impartial, competent analysis of its traffic safety problems. It has stressed the need for improvement in driver licensing, traffic-law enforcement, driver education, traffic laws and ordinances, vehicle-inspection requirements, highway planning, and public support of safety programs. The problem of the drunken driver has received special attention. The American Mutual Insurance Alliance is engaged in similar activities. Individual insurers conduct seat-belt campaigns, offer rate reductions for good driving records or for good scores on psychological tests of driving attitudes, and check on the performance of truck drivers.

Insurers liberally support the National Safety Council, an independent body for the promotion of safety in factory operations, on the highways, and in life in general, as well as other safety organizations.

Life Insurance

Prior to the twentieth century life insurers did not realize what opportunities for life conservation lay before them. While there is little that they can do in the individual case except for the distribution of health literature to individuals, they are contributing importantly to the general improvement of health and mortality. They contribute funds for the support of medical research through the Medical Research Fund maintained by some 140 com-

[6] H. W. Heinrich, "Industrial Accident Prevention," pp. 19–34, 50–65.

panies. They accumulate and furnish data on disease, injuries, and mortality that are of great value in public-health work. Many companies have cooperated with health authorities to provide better hospital and sanatorium facilities.

Limitations

The loss data of insurers furnish essential information on hazards. The late Edward Atkinson, a recognized authority on protection and prevention, said, "The only persons who can prevent loss by fire are the owners and occupants of the insured premises." The same principle applies to other hazards. It has been said that the best safety device is a careful man. Insurers show where efforts should be especially concentrated; they show what is best practice in safeguarding at that point; they offer concessions from the average rates for superior conditions, impose penalties for those that are inferior, or even refuse coverage if conditions are too bad. Thus they appeal to the pocketbook, which is said to be the strongest appeal. Beyond this they cannot go. Thenceforward, prevention is a matter for the individual and the community.

Insurance as a Cause of Loss

In one respect, the existence of insurance militates against safety; full, or nearly full, insurance may lead to a spirit of recklessness, or overinsurance may develop pronounced moral hazard. "Over-insurance leads to fraud, full insurance to carelessness, and even partial insurance to some diminution of watchfulness."[9] Insurers have sometimes been criticized for negligence in permitting overinsurance, particularly in the case of small amounts of fire insurance on household goods. One flamboyant exhibit was arranged by a fire department which had commissioned a man to seek insurance on household furniture at various locations in the city far in excess of the property on the premises. A hall was then rented, and in separate booths constructed about the walls were shown the few poor articles of furniture that had been in each of the premises, the insurance policy obtained being displayed beside them. It was intended to substantiate the charge that neglect to inspect the furniture had made overinsurance possible and that, therefore, the overinsured were tempted to arson. That the temptation would be presented by such conditions can hardly be denied, but the degree of temptation is not so great as appears at first glance, for the insured know that their claims will be care-

[9] Allan H. Willett, "The Economic Theory of Risk and Insurance," p. 114.

fully scrutinized and that in an apartment or tenement building, total destruction that would conceal the fraud would be unlikely. Before the insurers are condemned on these charges, consideration should be given to the expense involved in complete inspection of every such risk, and to the probable ineffectiveness of such inspection in view of the movable character of the property.

That losses from most perils are greater than they should be must be admitted. That a certain amount of such loss is due to effort to perpetrate fraud on insurance carriers cannot be denied, but the proportion is probably small. Neither can it be denied that the existence of insurance and certain insurance practices may have caused in some cases an increase in hazard. But the major cause is to be found in public apathy.

SOME PROBLEMS AND THE FUTURE

Much of the stimulation of employers and property owners to adopt preventive design, devices, and activities comes from insurers, who offer rate reductions or set up standards for qualification for insurance coverage. Governmental units, from the federal government down, require conformity to statutory and administrative requirements. Insurers, government, and individuals do much to promote prevention through organization, distribution of literature, conferences, and other public-relations efforts. And underlying all these activities is the constant study of means and results.

Much has been done, and much remains to be done, in getting effective cooperation of the public, from the individual person to the top management of corporations, legislators, and governmental administrators. Prevention often interferes with immediate convenience or ends and may involve considerable outlay of funds. The individual automobile operator enjoys speed, is eager to reach his destination, or just doesn't like interference; individuals in general like to pursue their ways unfettered. Management may be skeptical of the importance of prevention, may shun the organizing effort necessary, feel that cost is excessive, or hesitate to introduce possibly irksome rules. Legislators and public administrators are particularly sensitive to political implications, such as inability to "fix" tickets for traffic violations or imposing expensive or troublesome regulations on influential constituents. Too often it requires a dramatic catastrophe, such as the sinking of the *Andrea Doria* or the burning of the McCormick Exhibition Hall in Chicago, to stir the authorities to action.

Happily, however, gradual conviction of the broad practicality as well as humanity of sound prevention programs is improving the safety of environment and activities. And the phrase "sound prevention programs" should be

emphasized. Maximum safety might well be purchased at the expense of a minimum of activity and progress.[10]

QUESTIONS

1 How would you determine the point at which it is reasonable to halt an investment in a type of loss prevention?
2 Cite two examples of each of the four types of preventive and protective effort.
3 Classify your examples in Question 2 according to whether they emphasize the engineering approach or the human-relations approach.
4 Evaluate the charge that insurers do not devote any resources to the prevention of loss.
5 Evaluate the charge that insurance may increase expected losses.

[10] Detailed information on prevention is available in the following books: American Insurance Association, "Building Codes, Their Scope and Aims"; American Insurance Association, "Fire Prevention Code"; Factory Mutual Engineering Division, "Handbook of Industrial Loss Prevention"; H. W. Heinrich, "Industrial Accident Prevention"; National Safety Council, "Special Packet on Automobile Accidents"; Simonds and Grimaldi, "Safety Management"; and Tryan (ed.), "NFPA Fire Protection Handbook."

8
OTHER METHODS OF HANDLING PURE RISK

Important as insurance and the various methods of prevention may be, they are not the only methods of handling pure risk. This chapter completes the discussion of the tools of risk management with an analysis of (1) avoidance, (2) retention, including self-insurance, and (3) transfers other than insurance.

AVOIDANCE

One way to handle a particular pure risk is to avoid the property or activity with which the risk is associated. To illustrate, if a business does not want to be concerned about the risk of a fire loss to a building, it can avoid this risk by never acquiring *any* interest in the building. Alternatively, the ownership risk, but not all the pure risk, can be avoided by leasing the building instead of buying it. If a business does not want to worry about the potential liability associated with conducting a certain experiment or manufacturing a certain product, it can decide not to conduct the experiment or to manufacture the product. Finally, subcontracting part of a manufacturing, construction, or distribution task may enable a business to avoid some but not all of the risks associated with that job. In our personal lives we may also choose to avoid many risks such as those associated with sky diving or the ownership of an expensive motorboat. A business or family may choose to avoid a risk at one period in its history that it would be willing to assume at some other date.

Avoidance, therefore, is a useful and common approach to the handling of risk. Often, however, it is impossible or clearly impractical to use this approach. For example, one cannot avoid the risk of death or poor health. In other cases the potential benefits to be gained from owning some property or engaging in a certain activity may so far outweigh the potential losses and the risks involved that the decision maker gives little consideration to avoiding those risks. In other cases the decision is less clear, and the risk manager

must compare carefully the relative merits of avoidance and the other methods.

RETENTION

A business or a family retains the risk when it elects to bear any potential losses itself. In some cases it may not be aware of the fact that it has made such an election. It may not have recognized certain risks to which it is exposed, and by its failure to adopt any of the other methods, it has by default elected retention. In other cases the risk manager has properly recognized the risk but has underestimated the magnitude of the potential losses. The firm is automatically retaining the losses in excess of the risk manager's estimate. In still other cases the complete potential loss has been recognized but no decision has been made as yet on how to handle this risk. In the meantime the risk is being retained.

Retention is sometimes the only method possible. The loss cannot be completely prevented; the loss cannot be avoided; insurance is not available; and no one else is willing to accept the risk. In many areas flood damage to real property or potential liability losses in excess of some sizable amount furnish an illustration of such a risk.

Considerations in the Usual Case

The most interesting cases to consider are those in which the risk manager makes a conscious decision between retention and other risk-management tools. Usually the decision is between retention and insurance with loss-prevention-and-reduction measures being employed in conjunction with either retention or insurance. Retention appeals to potential insureds for the following reasons:

1 By retaining the risk, the business or family can save part or all of the insurer's expense loading. This expense loading is designed to cover the cost of acquiring the business (mainly selling expenses), adjusting claims, rendering loss-prevention services, and performing general administrative tasks. It also includes some provision for taxes and a profit-and-contingency factor.

In analyzing these potential savings the risk manager must recognize that some of these expenses are incurred for services rendered to insureds, and that, if he chooses not to purchase insurance, he must either forego these services, provide them himself, or purchase them elsewhere. Loss-adjustment and loss-prevention services provide the clearest illustration of this consumer benefit, but risk-analysis services provided by

the agent and the insurer should also be considered. Businesses are more likely to receive and to value these services than are families.

2 If the business or family believes that their expected losses are less than those assumed by the insurer in establishing its premium, they may reason that they can save the difference between the two expected loss estimates.

An understanding of insurance pricing such as that provided in Chapter 27 is important in evaluating this potential saving. Although most insureds pay the same rate as other insureds sharing the same major characteristics, some insureds are rated under a procedure that pays considerable attention to their unique characteristics or their individual loss experience.

One must also remember that the loss experience in any single year may differ considerably from the expected loss. This variation of the actual losses around the expected losses has been studied in Chapter 2. Chapters 2 and 3 also indicated why some persons are willing to pay much more for insurance than their expected losses in order to eliminate their uncertainty. The extra amount they are willing to pay depends upon their estimate of the variation in the losses, the severity of the potential losses, their ability to sustain these losses, and their attitude toward risk. Consequently, retention is more attractive when the individual has many independent exposure units because the relative variation in the annual losses will be small; i.e., the individual will be able to predict his losses fairly well. Retention is also more attractive if the firm or family would be able to sustain the potential losses with relatively little strain. This ability in turn depends upon the magnitude of the potential losses and the economic status and liquidity position of the family or the business.

In order to protect itself against unusually large losses, the business or family that elects to retain the risk may purchase excess insurance. This insurance usually provides protection against individual losses in excess of some stated amount, but sometimes it covers excess total annual losses.[1]

3 The opportunity costs involved in the timing of the premium payments relative to the alternative losses and expenses is another consideration. For example, even if the business or family reasons that the premium will probably be slightly less than the alternative losses and expenses, it might prefer to retain the risk if the time lag between the premium payment and the alternative loss and expense payments would permit it to

[1] Small deductibles in an insurance contract permit an insured to retain only the small losses. Even small deductibles may permit substantial premium savings because often most losses are small and small losses are relatively expensive to adjust. Deductibles may also reduce the morale hazard. See pp. 149–150.

earn an attractive rate of return on the declining balance of funds not yet spent for losses or expenses.

4 Some businesses believe that many of the services provided by insurers can be better performed internally or by independent service agencies. For example, they may believe that their own safety engineers can more effectively reduce the number and severity of losses because of their better knowledge of the firm and its employees. On the other hand, they may lack the breadth of experience possessed by insurer representatives. Whether employees are more likely to be influenced by a fellow employee or by an outsider is also a consideration. Independent servicing agencies are available for those firms who choose to retain the risk in question but who prefer the services of an outside expert.

Some businesses wish to handle their own liability or workmen's-compensation claims because of the potential good will value arising out of amicable adjustments. Others argue that an insurer or an independent servicing agency is valuable as a "buffer" between the business and disgruntled claimants. Some businesses believe that insurers are too lax in their adjustments if the firm's premium depends to a large extent upon its own claims experience, and that consequently by adjusting the claims themselves they can reduce their expected losses.

The tax implications of a decision to retain are too complex to be discussed here in detail, but the following basic consideration indicates why taxes cannot be ignored. A business (but not a family) can deduct the insurance premiums it pays in determining its federal income tax. Contributions to a retention fund (except to a pension plan qualified with the Internal Revenue Service) cannot be deducted. Instead the book value of any loss (i.e., the purchase price less accounting depreciation) is deductible.[2]

Funding Arrangements

Most decisions to retain do not involve any formal advance funding. The business or family simply bears the losses when they occur. This approach cuts administrative detail to a minimum, but if the losses fluctuate widely from year to year, the business or family may have to borrow money or sell property on unfavorable terms in order to develop the cash required to meet the losses. Another disadvantage for a business is that its operating statements are unduly influenced by chance results.

[2] For a more extensive discussion, see Frank A. O'Shaughnessy, "The Accounting and Tax Aspects of Risk Management," chap. XI in Snider (ed.), "Risk Management."

Fluctuations in the operating statements can be avoided by creating a liability account or earmarking some portion of the surplus that will be credited each year with an amount equal to the expected losses and debited with the actual losses. This liability or earmarked-surplus account, however, is a paper entry that does not affect the liquidity problem.

A more conservative approach would, in addition to creating a liability or earmarked-surplus account, establish a corresponding earmarked asset account consisting of assets that could be turned into cash with little difficulty. A family does not normally prepare balance sheets, but it could accumulate an emergency fund out of annual contributions. If losses occur soon after the earmarked account or the emergency fund is created, the liquidity problem will be only partially solved. The generally lower return on liquid assets will be a deterring consideration on the formation of such a fund.

Some businesses have funded their retention program by organizing an insurer whose sole (or major) customer is the business itself. Such insurers are captive insurers.[3] The major attraction of this method of funding a retention program is that the captive insurer can obtain certain covers from reinsurers, who deal only with insurers, that the business itself cannot obtain from insurers serving the public directly. Premiums paid to the captive insurer can also be deducted when determining the business' federal income tax. Possible disadvantages include the capital and manpower requirements to organize and operate a captive insurer and the special taxes that must be paid by insurers. On balance, interest in captive insurers appears to be increasing.

Self-insurance

Self-insurance is a special case of retention. It is not insurance, because there is no transfer of the risk to outsiders. In this text the term will be reserved for those retention programs that cover such a large number of exposure units that the business or family can predict fairly accurately what the losses will be during the budgeting period. This ability to predict the future is the common bond between the operations of insurers and self-insurers. Many writers would impose the additional requirement that earmarked funds be accumulated in advance. A captive insurer is a hybrid of insurance and self-insurance.

When there are enough exposure units to make a self-insurance program possible, the case for retention is strengthened but the other factors noted above must also be considered.

[3] See Robert Goshay, "Captive Insurance Companies," chap. VI in Snider (ed.), *op. cit.*, for a more comprehensive discussion.

NONINSURANCE TRANSFERS

The final tool of risk management to be discussed is a transfer of the risk through some device other than insurance. These noninsurance transfers can be divided into (1) transfers of the property or activity with which the risk is associated and (2) transfers of the risk only.

Examples of the first category include the sale of property, subcontracting part of a manufacturing, construction, or distribution job that a business had formerly done itself, and sending via a common carrier shipments that had formerly been transported on owned vehicles.[4] These examples, when compared with those on p. 90, illustrate the close relationship between transfer of the property or activity itself and avoidance. The difference between these two approaches is that the transfer method applies to risks that the family or business assumed in the past and now wants to transfer to someone else; the avoidance technique applies to risks that are never to be assumed.

The more interesting noninsurance transfers are those that transfer the risk but not the property or the activity. These transfers can be divided into two major categories: (1) hold-harmless agreements and (2) fidelity and surety bonds.

Hold-harmless Agreements

Under a hold-harmless agreement, one person, the indemnitee, attempts to shift a responsibility that would normally be his to some other party, the indemnitor. This agreement is usually incidental to the main purpose of the contract. For example, except in a few states where such agreements are illegal, a landlord may include in a lease an agreement under which the tenant becomes responsible for all losses to the premises or to third parties on the premises even if the loss is caused by the act or neglect of the landlord. If the tenant has the stronger bargaining power, he may impose a reverse obligation upon the landlord. Sometimes parties to the contract unwittingly impose such obligations upon one another.

A primary contractor on a construction project may be able to force his subcontractors to accept hold-harmless agreements under which they assume liability for certain pure risks that would normally be borne by the primary contractor. Purchase orders often include clauses under which a manufacturer or wholesaler agrees to indemnify and hold harmless a distributor against certain claims arising out of defects in their products. The customer of a bailee, such as a laundry, a processor, or a warehouseman, may find that the bailee has accepted in writing a responsibility in excess of his liability for

[4] For a discussion of the responsibility of common carriers, see p. 209.

negligence under the common law.[5] Railroads have been able through sidetrack agreements to shift certain risks to the customers they serve with a private sidetrack. These examples should be sufficient to illustrate the nature and scope of these agreements.

The transfer of risk under such agreements may or may not be complete. If the hold-harmless agreement is ambiguous in any way, courts have a strong tendency to favor the indemnitor over the indemnitee. Even if the agreement is legally airtight, the indemnitor may not be financially able when the occasion arises to reimburse the indemnitee for a loss covered under the agreement. For example, if a landlord transfers some of his liability risks to a tenant under a lease, he may still have to bear any losses covered under the agreement if the tenant is not financially able to do so. Sometimes the indemnitor is financially strong but will do its best to avoid paying the loss.

Most hold-harmless agreements are not as severe as the above discussion might suggest. Usually the contract does not transfer responsibility for the indemnitee's acts to the indemnitor. Instead it merely permits the indemnitee to seek reimbursement under the contract if he is held responsible for some act of the indemnitor. Otherwise he might have to sue the indemnitor to recover. For example, even though a manufacturer may be responsible for a defect in one of his products, a customer can often successfully sue the retailer who sold him the product. The retailer may possibly recover the amount he paid from the manufacturer, but through a properly drafted hold-harmless agreement he can avoid the uncertainties and possible expense and unpleasantness associated with a suit.

Hold-harmless agreements may impede loss-prevention-and-reduction efforts if they shift losses caused by the unsafe acts of one party to another party. Insurance costs may be increased because the indemnitor under such an agreement may be required to pay an additional premium. The indemnitee may not be entitled to any reduction in his premium because the value of the agreement may be uncertain for the reasons cited above. Business contracts become more complicated because of the inclusion of these agreements. Despite these difficulties, hold-harmless contracts, when carefully drafted and limited to financially secure and responsible indemnitors, can be an important tool of risk management.

Fidelity and Surety Bonds

Fidelity bonds provide protection against the dishonest acts of some party or parties. Surety bonds cover the failure of some party or parties to carry out some express obligation, such as a construction or a supply contract. This

[5] For a more detailed discussion of bailee responsibility, see pp. 210–211.

failure may be caused by dishonesty, but it may also be caused by incompetence, the failure of some persons not a party to the contract, bad luck, or some other reason. Companies issuing fidelity and surety bonds are classified under the insurance laws of most states as insurers. There are, however, excellent reasons for agreeing with bonding underwriters that, as to many types of bonds, the business of suretyship is not an insurance business.

Antiquity of Suretyship. When one person undertakes an agreement of any sort (e.g., gives his note for a sum due 3 months hence, or agrees to build a house, or even promises to restrain his temper and keep the peace), and someone else guarantees by endorsement or by some other binding engagement that he *will* do so, the second person is said to be a surety for the first. Suretyship is a very ancient practice. From the warnings against becoming surety for a stranger in the Proverbs of Solomon,[6] it may be inferred that voluntary suretyship was practiced as early as 1000 B.C. The taking of hostages in ancient warfare was the exaction of an onerous form of involuntary suretyship. The story of Damon and Pythias is based upon a voluntary suretyship, the terms of which were exceedingly burdensome.

Absence of Insurance Principle in Suretyship. Although the practice of exacting such severe terms has long since passed out, the practice of suretyship with financial guarantees has succeeded it and continued until the present time. Until the late nineteenth century, however, the guaranty was largely by personal surety. Though there were earlier proposals to form a surety corporation, none was actually formed before 1840, and the first company to undertake corporate suretyship in the United States did not do so until 1878.[7] The persons who acted as sureties for others did not generally undertake to do so as a business venture. They were not, like the early marine and fire underwriters, attempting to insure a number of risks and take advantage of the operation of the law of large numbers as applied to them. Usually the moving consideration was friendship and personal regard. One person was rarely surety for more than one or two friends. Sometimes there were prospects of reciprocal business preferences or other valuable inducement. But the voluntary character of the surety's action and the suffering frequently resulting were so noteworthy that it became a settled rule of law that the bonds of sureties were to be rigidly construed against claimants, and sureties were referred to as

[6] Proverbs 11: 15.
[7] See E. C. Lunt, "Surety Bonds," pp. 3 and 4.

favorites of the law.[8] Historically, therefore, suretyship is not to be classed as insurance.

Surety Underwriting. The historical evidence against considering suretyship as a form of insurance, though persuasive, is less convincing than that of certain present practices. For example, not infrequently a surety company will decline to issue a bond unless the person for whom the bond is required deposits with it collateral equal in value to the maximum possible loss under the bond. It may be questioned why a person would require such a bond. Certainly not for the same reasons that might lead him to buy a fire-insurance contract. Usually, such a bond is obtained in order to comply with a legal requirement on which the person's right to take some desired action is conditioned. Under it, there is no transfer of risk if the collateral is good (and usually, when taken, it is cash or its equivalent), for the surety can sustain no loss and the depositor stands to lose his whole deposit. Bonding underwriters look upon the writing of these bonds as a lending of credit backing only, and the premium on the bond as a fee for the service involved. It should not be inferred from this example that bonds are issued only when secured by collateral. Collateral is required in only a small proportion of any insurer's obligations, but this extreme type of case, which is by no means rare, is cited to bring out clearly a fundamental difference.

Real Service of Suretyship. What, then, is the purpose of suretyship? Perhaps its purpose can be seen more clearly by turning back to the practice of private suretyship. Bonds and sureties were not generally demanded where the parties making an agreement had confidence in each other, as to both integrity and ability, including financial ability. It was when some doubt crept in that surety bonds were called for.[9] The bond became a certificate of character, ability, and financial worth, an unusually strong one since the surety had risked his fortune on his own estimate of, and confidence in, the principal. Also, when one person goes on the bond of another, he does so only when he has the utmost confidence in that other. The risk is otherwise too great. It is in line with this theory that, when corporate suretyship was first proposed, it was frequently stated that a corporate bond was less satisfactory than a personal bond, for if a person did not have friends who would back him up, but had to go to a corporation for his bond and pay for it, there must be something wrong.

[8] See Edwin W. Patterson, "Cases and Materials on the Law of Insurance," p. 42, note (7).

[9] In modern business the surety bond is becoming a customary requirement.

Thus it appears that the function of the surety was to prevent loss by certifying those most certainly entitled to confidence, and that the bond was merely a formal backing up of the judgment that such person was so entitled.

Service of Surety Not Changed when Performed by Corporation. Since the undertaking of the business of issuing bonds by corporations, corporate suretyship has largely tended to displace private suretyship. The reasons why this should have come about are not far to seek. A man might be willing to place his own fortune in jeopardy for his friend if his friend's need were great and if he realized that that friend had no other way to meet it. But with corporate suretyship available at moderate cost, he naturally does not feel that he should take the risks involved merely to save his friend the expense of the corporate bond. Again, although the personal surety might be well worth the sum for which he went surety at the time the bond was executed, his fortune may have materially dwindled at the time a demand is made upon him under the bond. Consequently, those requiring others to furnish bonds have tended to specify that the bonds be those of surety companies. Where bonds are required by statute this is often the case.

With this displacement of private by corporate suretyship, some change has come about in the public attitude toward sureties. There is not quite the same sympathy and tendency to construe the bond strictly to protect the corporate surety for hire that there was for the voluntary private surety who might have become the victim of his own good nature. Most surety companies now also write some of the various lines of casualty insurance, and there is, therefore, a natural tendency in the public mind to consider the bonding business to be essentially an insurance business.

Most surety underwriters protest that this is a mistaken view. They will admit that, under the stress of competition, almost all fidelity bonds[10] are now written on an insurance basis, but they question whether this is really beneficial to those in whose favor the bonds are written, and they point out other types which could never be written on an insurance basis.

Most businessmen requiring bonds of their employees do not require bonds large enough to cover all possible stealings. There is thus a chance of loss in excess of the amount (or *penalty*) of the bond. But of more importance still is the fact that a dishonest employee may injure the business in various ways not covered by the bond, e.g., by giving it a bad reputation, an indirect injury which may be greater than direct stealing. Underwriters protest that a greater service is done employers by keeping them from employing dishonest men

[10] Including the blanket bonds discussed in Chapter 20. More than one-half of the premium income of the fidelity-bonding business is from contracts written on an insurance basis.

through refusing to bond them than would be done by distributing through insurance the loss due to their misconduct. The same reasoning applies to the bonding of contractors and others.

Notwithstanding this line of reasoning, it is often convenient for bankers and others employing many people to have bonds written that cover whoever may hold a particular position, rather than a named individual. This is particularly true where there are frequent or sudden changes in personnel. The employer is relieved under such bonds from keeping track of all changes and seeing that suitable bonds are filed by each person appointed to the staff. The surety company covering in this way is not certifying to the competence and reliability of those who may be covered by the bond, since it cannot, in the nature of things, have made an investigation which would serve as the basis of a certificate of this kind.[11] Consequently such bonds must be written on an insurance basis, and become in effect insurance contracts. Sometimes these bonds include much more than the ordinary risk of dishonesty of the employee. Competition between surety companies has led to an extensive development of such "blanket" bonding.

Traditional Form of Bond. The traditional form of surety bond is substantially as follows:

> Know All Men by These Presents.
> That.....of.....as Principal and.....of
> .....as Surety are held and firmly bound unto.....
> of.....in the penal sum of.....Dollars to the
> payment whereof to the said.....they bind their heirs,
> executors, administrators, successors and assigns.
> Whereas the said.....has been employed by the said
> .....as.....,
> Now, therefore, the condition of the foregoing obligation is that if the
> said.....shall well and truly perform the duty of
> .....then this bond shall be null and void, otherwise
> it shall be in full force and effect.
> Signed, sealed and dated this.....day of.....196...

The specification of what will invoke the penalty of the bond varies with the circumstances calling for the giving of the bond. Few are quite so all-inclusive as the example given.

[11] Many insurers arrange with employers carrying position bonds to have employees so bonded furnish applications and make the same investigations as for individual bonds, giving the employer the benefit of that service.

This form, with the necessary and suitable changes to adapt it to the case of a corporate surety, is still in use for many purposes. In some cases, it is specifically stated as the condition of the bond

> that if the Principal shall indemnify the Obligee for all loss the Obligee may sustain by reason of the Principal's failure to comply with any of the terms of the contract, then this obligation shall be void; otherwise it shall remain in force.[12]

This means that, if an obligation arises under the bond, the resources of the principal or his estate are subject to the first call, and the surety is liable only to the extent that the principal fails to make good.

Parties to a Bond. There are normally *two* parties to an insurance contract—the insured and the insurer. The above form indicates that there are *three* parties to a bond:

1 The party whose acts and responsibility are guaranteed by the bond. This party is the *principal* of the bond.
2 The party who is indemnified if any loss occurs that is covered by the bond. This party is the *obligee.*
3 The party who guarantees the performance of the principal and becomes liable with him if any loss occurs. This party is the *surety.*

Comparison with Insurance Contract. From the standpoint of the obligee the bond has much resemblance to an insurance policy, particularly after a loss has occurred. He usually immediately calls upon the surety to make good, especially if it is a corporation, and the latter puts such pressure as it can upon the principal to make good. If he cannot, or will not, do so promptly, the surety pays and makes such recovery as it can from the principal. There is the difference, however, that usually the obligee does not pay the premium on the bond but calls upon the principal to furnish the bond as the basis of the transaction, which will presumably be to his advantage. In this respect the position of the obligee is similar to that of a mortgagee who, as a condition of his loan, requires the mortgagor to provide insurance. It is now the usual practice of employers, however, to pay the premium on bonds guaranteeing the fidelity of their employees.

The premium charge by the surety includes, it is true, some margin for the payment of losses. In the case of contracts written on an insurance basis it is

[12] This language is taken from a bond guaranteeing the performance of a construction contract.

about as large a percentage as in other lines of insurance. But in other cases it is essentially a service fee for the investigation of the principal and the determination of his responsibility, or a fee for the lending of credit. Bonds are given principals when it is practically certain that the obligation under the bond will have to be met, but the surety makes sure that the principal will pay by requiring him to deposit with it collateral equal to the penalty of the bond and to make this deposit under an agreement that gives the surety the right to dispose of the collateral as it sees fit. An example of his type of bond is one filed by the loser in a judicial proceeding to secure a stay of execution pending an appeal. Since in only about 25 per cent of cases appealed is the first decision reversed, it is a reasonable assumption that the appellant will lose. Were such bonds written on an insurance basis, the premium would be impracticably high.

To emphasize the difference in underlying character between most bonding transactions and true insurance transactions, it may be well here to note one other type of bond and the practice under it, viz., the bond of a fiduciary, such as a guardian of a minor. It is frequently the practice of the surety to demand, as a requirement before it will issue the bond, that it have joint control of the estate. This, when granted, means that all checks must be countersigned by its representative, and that securities and other negotiable assets must be kept in a safe-deposit box to which the guardian is to have access only jointly with the surety's representative.

The peculiarity that brings about these requirements is the fact that a large part of the risk under a bond is a moral risk. There may be a risk of inadequate resources or inexperience under a construction contract bond, but even in that case the risk of dishonesty is present. The joining of the principal with the surety in the promising of indemnity is, in a measure, a guard against this risk. Collateral and joint control are additional safeguards, but the chief reliance is upon careful investigation of the principal.

Discussion of the major types of surety bond will be deferred to Chapter 20.

QUESTIONS

1 Cite some illustrations of risks to which the avoidance technique might be applied.

2 Retention is often classified as either active retention or passive retention. What types of retention would you consider to be active? passive?

3 A business is considering the retention of workmen's-compensation losses. What factors should it consider in making its decision?

4 A family purchases automobile collision insurance wtih a $100-deductible policy. What tools of risk management has it employed?

5 How should a business fund a self-insurance program?
6 What are the advantages and disadvantages of hold-harmless agreements as a tool of risk management?
7 Why is personal surety usually less satisfactory to an obligee than corporate surety?
8 From the principal's point of view, what difference is there between the promise made by a corporate surety and that made by a liability insurer?
9 It is often contended that bonding is not insurance. To what extent is this contention accurate?

2
INSURANCE CONTRACTS

Comprehension of insurance in general or of any particular branch of insurance requires understanding of the insurance contract, its general principles and its particular applications. Few insureds read their contracts, and fewer understand them. Not only are they phrased to a large extent in technical terms, but their apparently clear English takes on special meanings as a result of custom, negotiation, or court interpretation.

Part 2 discusses the principles applicable, with some exceptions, to insurance contracts in general, certain types of provision common to a wide range of contracts, and the contracts used in the principal classes of insurance. The authors feel that the basic importance of the contract in insurance fully warrants the allotment of major attention to it. In discussing principles, provisions, or specific contracts, no attempt will be made to be encyclopedic or to catalogue; the reader should turn to the contract form under consideration for detailed provisions.

In spite of a high degree of standardization, there are considerable competitive variations in basic contracts, notably in the health, marine, and automobile-insurance fields. Further variations are found in endorsements, whether designed to adapt general contracts to particular situations or to be offered competitively. These chapters will deal with the more widely accepted contracts, both their basic forms and the principal endorsements applicable to them.

In studying the contract one should have in mind three primary aims: (1) acquiring comprehension of the meaning of the contract, (2) developing a sense of the proper approach to the making of a contract—of having it so drawn that, in event of loss, questions of meaning will not arise, and (3) distinguishing between provisions that give needed protection or service and those that are designed largely to serve as selling points.

No contract forms are reproduced in the appendixes of this edition. Up-to-date specimen forms are available in kits supplied by the American Mutual Insurance Alliance, 20 N. Wacker Drive, Chicago 60606; the Health Insurance Institute and the Institute of Life Insurance, 277 Park Avenue, New York,

10017; and the Insurance Information Institute, 110 William Street, New York, 10038. Study of appropriate forms in connection with each chapter of Part 2 is suggested for the reader desiring a more detailed knowledge of insurance contracts. Specimen contracts may also be secured from insurers or their representatives.

9
FUNDAMENTAL LEGAL PRINCIPLES

In order to analyze and interpret insurance contracts, it is important to keep in mind certain fundamental legal principles. The insurance contract is subject to many of the general rules of contract law, but because of its unique characteristics it possesses certain peculiar legal aspects. This chapter emphasizes these unique characteristics and some of their resulting legal effects.

ESSENTIALS OF A CONTRACT

While their application to insurance is of a specialized nature, there are several important general rules, conformity to which is essential to the making of a valid contract of insurance:

1 The contract must express an agreement offered by one party (insurer or insured) and accepted by the other. The time when the offer is legally accepted is important because it often marks the effective date of the contract.
2 The parties must have capacity to contract, i.e., be legally capable of contracting.
3 The contract must be supported by a valuable consideration.
4 The contract must not be illegal nor made in furtherance of illegality, immorality, or conduct contrary to public policy.

Since these rules are applicable to contracts in general, they need not be discussed except to point out that minors have, in certain states, by statute and subject to stated limits, been made competent to make, and act under, life-insurance contracts; that the accidental results of certain illegal activities may be insured against; and that offer and acceptance have certain technical interpretations peculiar to insurance. For example, in property insurance the agent is assumed to invite the applicant to make an offer to the insurer. The contract becomes effective when the insurer accepts the applicant's offer. In life insurance, unless the applicant makes his premium payment with his

application, he is assumed to be inviting the insurer to make an offer, which he may then accept or reject. The remainder of this chapter is devoted to principles peculiar to insurance, or of special importance to insurance.

UNIQUE CHARACTERISTICS OF INSURANCE CONTRACTS

According to one noted authority on insurance law,

> Most of the peculiar legal aspects of the insurance contract arise from the fact that it is an *aleatory* as distinguished from a *commutative* contract. In making the latter type of contract, the parties contemplate a fairly even exchange of values. In a sale, which is a typical commutative contract, the seller thinks that the price paid is about equal to the value of the goods, and the buyer expects to get goods about equal to his price. On the contrary, in making an insurance contract, the insured knows that he is paying a sum far less than the insurer is to pay him *under certain conditions* that will probably not occur. Insurance is an aleatory contract; the conditions are a part of the bargain. They define the risks that the insurer agrees to bear for a group of persons exposed to similar risks and paying similar contributions to the fund from which losses are to be paid.[1]

Other unusual characteristics, however, are also important. All insurance contracts are *personal* contracts in the sense that the insured's identity is important to the insurer. Furthermore, although a life-insurance contract can be assigned to some other party without the insurer's consent, the assignment of a property- or liability-insurance contract is usually not valid unless the insurer consents to the assignment. The assignee may be less attractive than the original insured to the insurer even if the property or activity is the same. Life-insurance contracts are made freely assignable because the life insured is not changed and the insured is not likely to assign the contract to a person who will cause his death.

If the insured pays a premium before or at the inception date of the insurance contract, it is a *unilateral* contract. Only the insurer is legally bound to do anything at some future date. The insured has done everything that he can be forced to do. On the other hand, because the insurance contract is also a *conditional* contract, the insurer can refuse to perform unless the insured satisfies certain conditions, such as the submission of a proper proof of loss or the avoidance of certain hazards.

Insurance contracts are usually *contracts of adhesion.* Although professional risk managers increasingly participate in the drafting of tailor-made

[1] Edwin W. Patterson, "Essentials of Insurance Law," p. 62.

contracts, most insurance contracts are prepared exclusively by the insurer, who presents a printed document for the insured's consideration.

In the interpretation of a policy provision the meaning of which is not clear, the court will construe the provision "most strongly" against the insurer, on the ground that the insurer prepared the contract and should have made it clear. This rule of construction is even applied in the interpretation of contract provisions required by statute, on the reasoning that such provisions were originally drawn or were based on provisions drawn by insurers and are in their language. In some cases, however, the courts have held that, where the language is dictated by the state, insurer and insured are to be considered as on an equal footing, and the provision is to be enforced as written. But the rule may not be used to deny the ordinary, generally accepted meaning of words in order to enable the insured to collect.

The two remaining characteristics are so complex and so important that they will be considered in some detail.

A CONTRACT OF INDEMNITY

Payment of loss under a property- or liability-insurance contract is enforceable only to the extent of the actual loss to the insured resulting from a peril insured against, since the insurance contract is a *contract of indemnity*. To enforce payment of a greater amount, even though it were promised by the insurer, would be contrary to public policy. It would, to the extent of the excess amount, mean enforcement of a wager contract, which increases risk rather than diminishes it. Further, expectation of being able to collect more than the amount of loss, and therefore of having his financial position improved by the loss, would tempt the insured to cause the loss or at least lead him to have less interest in preventing it. The four features described below combine to make these contracts of indemnity. Life-insurance contracts and most health-insurance contracts are technically not contracts of indemnity because they lack at least one of these features.

Measure of Loss

In determining the amount of loss payable under a property- or liability-insurance contract, only financial loss may be considered—loss that can be estimated by objective standards. An insured might place great value on a table because of its association with his family, but his estimate of the value would be subjective, resting entirely on sentiment, with no objective check. Moral hazard would evidence itself in temptation to overvalue the table.

In considering property, the usual provision is that the value is the *actual*

cash value, and actual cash value is generally held to be the cost to replace the property or to repair it, if damaged, *at the time of the loss.* Depreciation, if any, must be deducted from the value new as of the time of the loss. Original cost or book value as such has no probative force. It is usually provided that the insurer will not be liable for loss to an amount greater than it would cost, at the time of the loss, to repair, or replace "with material of like kind and quality."

While cost of replacement, less physical depreciation, is the usual measure of loss, obsolescence, particularly if marked, may be considered. This exception to the general rule was applied in a famous leading case[2] where the insured claimed that the value of a brewery, destroyed by fire during the prohibition era, was, for insurance purposes, the replacement value less physical depreciation. The court decided that, among other things, "obsolescence of the structures or their inutility for commercial or manufacturing purposes" might properly be considered. The exception may be applied to elaborate dwelling houses constructed in a bygone era and located at the time of loss in a run-down neighborhood.

In one case it was decided by a jury that no loss had been incurred when a building, in course of demolition but still about 90 per cent intact and to be replaced by a new building in course of construction and immediately adjacent, was destroyed. While the verdict turned partially on lack of evidence, the appellate court ruled that the jury was justified in its finding and that the verdict "could in no event have been for more than nominal damages."

On the other hand, the actual cash value of new seasonal goods, such as straw hats, destroyed too late to permit replacement in time to supply the market, *may* be considered to be the selling price rather than the cost of manufacturing or replacing them. Contracts sometimes provide that the measure of the loss will be the cost of replacement new or selling price (less selling expenses).

Policies covering consequential property losses such as the loss of profits or the expenses that continue during a business shutdown usually limit recovery to actual loss sustained. Liability-insurance payments benefit directly the injured party, not the insured.

In some property lines *valued policies* are written. Under these policies, agreement on the value of the property insured is made a part of the contract, and the amount agreed upon is payable by the insurer in case of total loss. Such contracts are found principally in fields in which the determination of value after loss is difficult, especially where objective estimates may vary rather widely. Examples are antiques and works of art, particularly if unique.

[2] *McAnarney v. Newark Fire Insurance Co., et. al.,* 159 N.E. 902, 247 N.Y. 176 (1928).

To the extent that they are written for convenience and not as a means of avoiding the rule against wagers, they are enforceable at law. Mere difference of opinion between the court and the parties as to the value is not sufficient, but gross overvaluation or other evidence of an attempt to circumvent the indemnity principle would be ground for avoidance. Some states have *valued-policy laws*, making the amount for which property is insured payable in case of total loss of the property, regardless of its actual value. Such laws reflect the theory that an insurer should not charge premiums for insurance greater in amount than the possible liability to the insured and that the insurer should take steps to prevent the face amount of the policy from exceeding the value of the property. They are believed to have been inspired by resentment caused by early practices of some insurers, particularly in agricultural states. While these laws may encourage some destruction of property, their effect is limited, since they apply only to cases of total loss.

Life-insurance policies and health-insurance policies covering disability-income losses are always valued policies.[3] A stated amount is payable upon the occurrence of a specified event. No exact measurement of the loss is possible in case of death or long-term disability. Although insurers attempt to avoid overinsurance at the time they issue the contract, a change in circumstances may cause the insurance payment to exceed the loss. Medical-expense-insurance policies, on the other hand, usually pay only the actual expenses incurred.

Insurable Interest

In property or liability insurance an insurable interest is an interest of such a nature that the event insured against might cause financial loss to the insured. The amount of such an interest at the time of the loss is the limit beyond which the insured is not entitled to indemnity, since he cannot lose more than the amount of his insurable interest. And he must have something to lose, since otherwise his insurance contract would be purely a wager contract.

This does not mean that an insured without insurable interest may not apply for, and secure in the market, a policy of property and liability insurance. But if he does not possess an insurable interest at the time of the loss, he will not be entitled to any recovery.

In life and health insurance, except possibly in medical-expense insurance, where the law is not clear, a person applying for insurance on the life of

[3] Some long-term disability-income contracts limit the benefit if the total amount of such insurance exceeds the greater of (1) the insured's monthly earnings at the time he becomes disabled or (2) his average monthly earnings for the two preceding years.

another must have an insurable interest in the life or continued health of the insured person at the inception of the policy. However, this interest need not exist at the date of loss. Unlike the situation in property and liability insurance, therefore, the beneficiary may benefit from the loss. Another difference, which is illustrated below, is that the insurable interest need not involve a demonstrable potential *financial* loss.

Examples of Insurable Interest. The sole and unconditional owner of property has an insurable interest in that property; this is the simplest type of insurable interest. But it is far from being the only insurable interest. A mortgagee to whom the property is mortgaged as security has an insurable interest to the extent of the mortgage debt. A lessee required by his lease to surrender property in the condition in which he received it has an insurable interest. Independent of any requirement of maintenance, a lessee has an insurable interest up to the value of his lease, whether it is due to established location, rent lower than current market rate, or other cause.

An interest need not be in existence to be insurable. It may be inchoate if founded on an existing interest. For example, in the case of property left in trust for a life tenant, the remainderman has an insurable interest, and a beneficiary under his will has such an interest if he is in possession or has a contract right to the property. A kinsman of the remainderman, even though promised that he will be remembered in the latter's will, has no such interest.

A mere expectation is not generally regarded as a sufficient basis for an insurable interest, but in New York and several other states, a substantial expectation of pecuniary benefit is insurable. An expectant heir has ordinarily no insurable interest before he actually inherits.

The possibility of certain losses, less immediate but incidental to the insured's situation, may give rise to an insurable interest. The owner or operator of an automobile is subject to claims for damages alleging injury to persons or property; the operator of a business may lose profits that would have been made but for the interruption of his business by a casualty.

If an individual purchases a life- or health-insurance policy covering his own life, the question of insurable interest does not arise. Persons such as the insured's wife are presumed to have an insurable interest as a result of their "love and affection" for him as established by a close blood relationship or marriage.

A corporation has an insurable interest in the life of an officer or employee who may be expected to render services of exceptional value. It could hardly have such an interest in the life of an office boy, but would have in that of an engineer or other "key man," for his death might cause loss to the corporation.

Other Insurance

Most property- and liability-insurance contracts provide for modification of the insurer's obligation if there is other insurance granting the same coverage in whole or in part. The purpose of this modification is to prevent the insured from collecting more than the amount of his loss through duplication of coverage.

Under the common law an insured may collect a loss from any insurer whose contract covers it, and that insurer may collect from others whose contracts cover the loss in the proportion that the insurance under each contract bears to the total under all contracts, i.e., pro rata. But any special provision in a contract governs the settlement under that contract.

The simplest provision carries out the principle of the common law, but limits the insurer's liability to the insured to its proportion of the total insurance. Suppose, for example, one has three contracts, each covering loss by windstorm, and in amounts of $2,000, $3,000, and $5,000. If a windstorm loss of $2,500 occurs, the insurers will be liable for $500, $750, and $1,250 respectively.

In some cases, it is provided that the insurance is excess, that it covers only after other insurance is exhausted. If the other insurance has no similar provision, the insurer is liable for payment of loss as provided by the excess clause. Suppose that one has $5,000 of insurance against a specified peril under a contract without the excess clause, and also $5,000 under a contract with the clause. If there is a loss of $6,500, the first insurer will pay $5,000, and the second $1,500. If both contracts contain the excess clause, the settlement will ordinarily be on a pro-rata basis; such clauses in two or more contracts covering the same loss have been called "mutually repugnant" and their observance "impossible of accomplishment."

Under some contracts the existence of other insurance avoids the contract; under others specific permission is given for other insurance.

Life-insurance policies do not contain any reference to other life-insurance contracts, but when a person applies for life insurance he is required to describe the policies he already owns. Presumably the insurer will not issue the contract if to do so would cause him to be overinsured. The situation in health insurance is similar, but increasingly, particularly in medical expense insurance, the contract itself deals with the problem of duplicate benefits.

Subrogation

Under contracts of property or liability insurance the insurer is *subrogated* to any rights of the insured to collect his loss from a third party to the extent that

the insurer has indemnified the insured. However, if the indemnity paid by the third party is less than the amount of the insured's loss, the insurer's claim to reimbursement is usually subordinate to that of the insured. For example, the owner of a house that is damaged to the extent of $5,000 by a fire negligently allowed by John Doe to get out of control may have an insurance contract for $3,000, which amount he collects from the insurer. John Doe is liable for the damage, but only $4,000 can be collected from him. By the prevailing rule the insured would be entitled to $2,000 and the insurer to $2,000.

The insured may have a right to collect from some third party because it is his fault that the loss occurred or because he has a contractual right to do so under a hold-harmless agreement. In the first instance, in addition to being consistent with the indemnity principle, subrogation rights increase the likelihood that wrongdoers will be forced to respond for damages they may have caused.

Life insurers do not possess subrogation rights, the theory being that because the value of a human life is unlimited, the insured's beneficiaries should be able to collect additional monies from persons who caused the insured's death. Until recently the same principle prevailed in health insurance because of the difficulties in measuring pain and suffering, but medical-expense-insurance contracts increasingly give insurers such right. This change, combined with other insurance provisions, is turning many medical-expense-insurance contracts into contracts of indemnity.

If the insured, without the consent of the insurer, settles the claim against the third party and so cuts off the rights of the insurer, he forfeits his claim under the insurance contract. If the insurer has already paid the claim, the insured must repay the amount received. But the insured may, in advance of the occurrence of a covered casualty, agree to relieve a third party of liability for damages due to the peril insured against. The insured thereby cuts off the insurer's right to subrogation, but does not impair his own right to collect his loss from the insurer, unless he has otherwise agreed in the policy contract.

CONTRACT UBERRIMAE FIDEI

The insurance contract is an agreement *uberrimae fidei;* i.e., of the utmost good faith. Both parties to an insurance contract are expected to disclose all the facts relevant to the transaction. The legal questions involving this characteristic usually center on the disclosure of information by the insured. The three most important legal doctrines are those of concealment, misrepresentation, and warranty.

Concealment

Concealment or failure to disclose material facts gives grounds for rescission (avoidance) of the contract by the insurer. A fact is considered to be material if it would influence the insurer in deciding whether to accept the risk or in fixing the terms (including the price) of the contract.

While this is the general rule, the specific rules governing the effect of concealment vary. In marine insurance, the insured must disclose every material circumstance known to him. In Great Britain, he is, in addition, deemed to know every circumstance that, in the ordinary course of business, ought to be known by him. Whether the nondisclosure is innocent or fraudulent (i.e., intentional) makes no difference. In the United States innocent concealment is ground for rescission of a marine-insurance contract, but only intentional concealment in nonmarine insurance.

The basic reason for these rules governing the effect of concealment on the insurance contract is that the insurer is often not in a position to discover, even by diligent investigation, all the material facts bearing on the acceptability of the risk and the terms of the contract. This is true in considerable measure in all kinds of insurance, but particularly in marine insurance.

Representations and Warranties

Information communicated by the prospective insured may relate to the present, past, or future. As to the past or present, it may relate to facts or beliefs. As to the future, it can only be promissory.

The communication may take either of two forms: (1) *representation* or (2) *warranty*. Representations or warranties may be made in response to inquiries by the insurer. Representations are antecedent to the insurance contract, may be oral or written, and are normally made to induce the insurer to make the contract. In order to rescind a contract on the basis of a representation, the insurer has to prove both that it was false and that it was material. It need not relate to a cause of the loss but must be such that, if the truth had been told, the insurer would not have made the contract on the terms on which it was made.[4]

A warranty is of the same nature as a representation, though stronger because it is a condition of the insurer's promise. Warranties are written and are a part of the contract. It is a much greater protection to the insurer

[4] In some states a defense of misrepresentation is permitted only when the loss arose from a cause as to which there was misrepresentation.

against incomplete or misleading information because under this form the insured bars himself from raising the issue of materiality. If he warrants that certain things are so or will be so, the warranty must be literally true as to the past, and strictly complied with if relating to the future. The latter type is a *promissory warranty*. Hence, any falsity in a warranty entitles the insurer to avoid the contract, whether or not the facts that constitute the breach of the warranty are material to the risk. The doctrine of warranty is very harsh and, if strictly enforced, may work undue hardship on the insured. As the courts are reluctant to declare a forfeiture except as a penalty for patent bad faith, there is a tendency to be lenient in the construction of warranties; but, if it is a clear case of warranty and not contrary to statute, the warranty will be enforced.[5]

Abuse of Warranties and Modern Legislation. When the doctrine of warranties was first worked out, the practice of insuring was confined largely to merchants and shippers who, in many cases, were also underwriters and who, therefore, fully appreciated the force and significance of warranties. The development of fire insurance covering private dwellings and of personal insurance—life and health—however, brought in a new class of insureds unfamiliar with the practice of insurance in general and with the legal theory of warranties. These insureds often signed applications for insurance giving their best understanding of certain matters and looked upon their statements as representations of no greater importance than would be attached to ordinary commercial transactions. Sometimes the printed part of the blank made them warranties. Under stress of competition, it also was very often the custom for the agent of the company to fill out a schedule of warranties on a policy which provided that, by his acceptance of it, the insured warranted the truth of the statements in the schedule.

These practices tended to produce many unjust forfeitures, and these forfeitures, in turn, tended to a judicial softening of the old doctrine. In many states, legislation provides, in regard to one or more kinds of insurance, that in effect and in the absence of fraud, all statements shall be deemed representations and not warranties. Other statutes permit the insured to recover unless the breach of warranty increased the expected loss or in a material way adversely affected the hazard assumed by the insurer. These statutes give the insurer ample protection, since a misrepresentation of a material fact will

[5] Of course, if fraud can be proved, the insurer may repudiate the contract without relying on the doctrines just cited. It is exceedingly difficult to prove fraudulent intent, and these legal doctrines were developed to discourage fraud when the fact of fraud could not be proved.

See also discussion of incontestability of the life-insurance contract, p. 311.

make the contract voidable. Yet the unscrupulous insurer is prevented from taking technical advantage of the insured. Usually associated with such legislation, as an additional protection to the insured, is a requirement that the application or any other document will not be incorporated in the contract by reference unless a copy is endorsed upon or attached to the contract when it is issued. This legislation does not apply to all branches of insurance, and in some, notably marine insurance, warranties are still used and are strictly enforced by the courts.

DIVISIBILITY

For convenience, more than one subject of insurance or kind of insurance may be included in the coverage of a single policy form. For example, the owner of several separate buildings may insure them all under one contract form, or the owner of an automobile may cover loss to his car and loss due to liability claims under one form. If, in either case, the form is considered to embody a single indivisible contract, failure to conform to a condition in respect of one part of the contract that would avoid the contract would avoid it in its entirety.

But judges, as a matter of equity and to obviate technical forfeitures, look kindly on the doctrine of divisibility, the application of which treats a single document as the embodiment of two or more distinct contracts. For example, if separate amounts of insurance and separate premiums are stated for the various buildings insured, it might be held that the contract insuring each building is a separate contract of insurance, unaffected in each case by any breach affecting one of the others. But if the breach in one case increases the hazard in another, these contracts would not be divisible.

Similarly, if a misrepresentation relevant to fire insurance on the automobile avoided the fire-insurance cover, it might well be held not to affect the validity of the liability-insurance contract.

The decisions in such cases are conflicting and depend largely on the circumstances of the particular case rather than on clear-cut rules.

CORRECTION OF MISTAKES IN CONTRACT

When a claim is made under an insurance contract and the insurer denies liability, the insured may argue that a mistake has been made in drawing the contract and that the mistake should be corrected to express the agreement which he negotiated and which would cover the claim.

> The word *mistake* is used in various senses. Sometimes, it means the doing of something; sometimes, the consequences of doing something; and at other times, the beliefs or suppositions that motivated the action.

> Suppose that A insures his house, worth $12,000, for only $10,000 and it is totally destroyed. The act of taking out the $10,000 policy was a mistake; the result of the act, being underinsured, might be called, somewhat loosely, a mistake; and the erroneous supposition of A that the house was worth (i.e., could be rebuilt for) only $10,000 was a mistake. The last sense is the one in which the word is commonly used in the law relating to correction of mistakes. The law does not relieve a party of the consequences of his act merely because those consequences were unforeseen or undesired; it does not correct his mistakes of judgment. Nor does it relieve him of the consequences of *all* erroneous suppositions of fact. The illustration just given is a typical situation in which no court would relieve the insured of the consequences of his own folly. Courts do not ordinarily relieve sane adults of their mistakes in judgment. They will under some circumstances relieve parties of their errors in expression.[6]

If the insurer argues that the insured accepted the written contract without objection, the insured may point out that he was justified in assuming, without reading it, that the contract embodied the agreement as negotiated. In most cases the insured will be upheld in this contention, but as a practical matter, he should read the contract and arrange with the insurer, if possible, for correction of mistakes *before* a claim is made.

Where it is clear that a contract covers a particular property or situation, but an error in writing it raises a question, the court may correct it by *interpretation*. For example, if the contract describes John Doe's house, occupied by him as a dwelling, at 362 Elm Street, and the number has been typed on an endorsement as 3622, the court would presumably correct the error.

At times, however, the error is not clear from other language in the contract, and it is asserted by the insured that the written contract does not embody the agreement entered into between him and the insurer. In that event, the court may be asked to grant *reformation* of the contract. Reformation will be granted only where it can be shown that there was an understanding between the parties and that the understanding was not expressed in the written document as a result of a mutual mistake or a mistake on the part of the party bringing the action of which the other party was aware. If it could be shown, for example, that an owner of several houses requested an agent (with authority) to insure a house at 786 Maple Street and that the agent, in the hurry of business, set down the address as 786 Main Street, the court would reform the contract to express the true intent of the parties. It would not be reformed if the mistake were unilateral, for example, if the insured had said "786 Main Street" when he should have said "786 Maple Street."

[6] Patterson, *op. cit.*, p. 102.

Renewals

If, without indication of any change, an insured asks an agent to renew an existing policy, and the agent agrees to renew it, the insured may rely on the new policy being the same as the old, except that its inception date will be that of the expiration of the existing contract.

WAIVER AND ESTOPPEL

Questions frequently arise as to whether an insurer has so expressed itself or so acted that it has waived (relinquished) a right or advantage that it would otherwise have under its contract or that it should be estopped from asserting that right. If a clear statement to that effect appears in the basic contract or in an endorsement, the question is easily answered in the affirmative. But often it is claimed by the insured that waiver or estoppel has been implied by a statement outside the formal contract or by an act. In addition to the question of implication, there may be the further question whether the person making the statement or performing the act had authority to bind the insurer.

For example, an agent of an insurer may learn that a condition in an insured's building is in violation of the standard contract of fire insurance. He acquired this knowledge while soliciting a contribution in a charity drive. He nevertheless writes a standard contract, without express waiver of the violation. Two questions arise: Did he have authority to waive the violation? Was his act in writing the contract a waiver?

Some courts distinguish between waiver and estoppel; others use the terms interchangeably. Where the distinction is made, a waiver is usually considered to be a voluntary relinquishment of a known right. For example, an insurer may tell the insured that he is excused from some condition in the contract. Estoppel involves more indirect actions on the part of the insurer. For example, the insurer whose agent wrote the policy cited in the preceding paragraph did not technically waive the violation but his action may estop the insurer from denying coverage later because of the violation. Even lawyers sometimes find it difficult to distinguish between the two doctrines, and no further attempt will be made to do so here.

Waivers by the insurer up to the time the contract is issued are likely to be upheld by the courts because the insured had not had an opportunity to read his contract up to that time. Insurers are also often found to have waived certain conditions in the contract following a loss because they have requested too much of the insured during the loss investigation, thus causing him to believe that his loss is covered. Courts are least likely to find that insurers have waived any rights by their actions after the policy was issued but before

a loss. Their decisions depend upon (1) the degree of ambiguity in the breached condition, (2) the authority of the insurer's representative who is accused of the waiver, (3) the kind of action which is supposed to have constituted a waiver, and (4) the seriousness of the breach.

QUESTIONS

1 Smith's home was built in 1950; it is destroyed by windstorm in 1969. Assuming sufficient valid insurance, what factors will determine the amount of loss collectible from the insurer?

2 Jones sells his automobile to Brown. As part of the transaction he assigns his insurance contract against loss of the automobile by fire or theft to Brown. The automobile is damaged by fire after Brown has taken possession and during the term of the contract. What are Brown's rights under the contract?

3 A prospective insured, in arranging for fire insurance on his building, states that it has a "noncombustible roof," believing that the roof is properly so described. The insurer charges a premium lower than it would have done had the roof been accurately described. A loss occurs, and the insurer, discovering that the roof is "combustible," refuses to pay. May the insured collect?

4 An insured has instructed his insurance agent to effect insurance against loss by burglary at his home in Mount Kisco, New York, but to bill him at his New York City office. Inadvertently, the address of the house is typed in the contract as New York City. The insurer refuses to pay a loss on the ground that its insurance does not cover in Mt. Kisco. What remedy, if any, has the insured?

5 Davidson insures his life in the amount of $10,000, naming his friend Chapin as beneficiary. Davidson's only financial relation with Chapin is that of a loan of $2,000 made by Chapin to Davidson several years after the inception of the life-insurance contract. Is Chapin entitled to payment under the life-insurance contract? If so, to what amount?

6 Why are life-insurance and health-insurance contracts not contracts of indemnity?

7 Larson accidentally sets fire to his own home, and the fire spreads to Olsen's home. Both men have fire insurance on their homes and liability insurance covering their personal activities. What insurers are involved in the loss settlement?

8 A student warrants that his car will be principally garaged in a rural area. Actually he keeps his car in a large city for which the automobile-insurance rates are much higher. Four months later he suffers a loss.

Can he collect from the insurer? Why or why not? Would your answer be different if the insurer's agent knew where the car was kept when he wrote the contract?

9 A hotel was constructed in a prosperous manufacturing town and for years did a profitable business. Geographical displacement of a considerable part of the town's business has made the hotel unprofitable, and it has not been kept in good repair. What should be considered in determining its actual cash value for insurance purposes?

10 An owner of real estate annually writes down the value of a building on his books at the rate of 5 per cent of the cost of construction. If the building were destroyed, what weight would be given to its book value in determining the amount collectible under an insurance contract covering the loss?

10
FORM OF THE CONTRACT

The words "contract," "policy," and "policy contract" are used interchangeably in insurance. If any distinction is to be drawn, it may be that "contract" connotes agreement, while "policy" connotes form or document. Since "contract" is the functional word, it will be given preference in this text. Another reason for preferring the word "contract" is that in many lines of insurance the contract always consists of a basic policy plus a form that adapts the contract to a particular kind of insurance or to the needs and desires of particular insureds.

Forms of contract differ widely, both between kinds of insurance and within individual classes. Some are rather simple, others highly complex. This chapter explains whether insurance contracts must be in writing, the extent to which they are standardized, and the major divisions of a typical contract. The chapter closes with a brief discussion of binders and renewal contracts.

ORAL CONTRACTS

With some exceptions, oral contracts of insurance are enforceable. The Statute of Frauds, in effect in most states, requires written and signed proof of an agreement which "by its terms is not to be performed within one year from the making thereof." Since a loss may occur previous to the end of one year, an oral insurance contract for a term of more than one year is not invalid under the statute. The difficulty lies in proving that such agreements have been made and, if made, in deciding their terms. Have the insured or his broker and the insurer or its representatives (with adequate authority) agreed upon the perils to be insured against, the subject of the insurance, the name of the insured, the name of the insurer, and the amount of insurance? Even if these terms are definite, much must be supplied by implication, since a complete insurance contract is a lengthy and detailed document. In case of disagreement as to the terms of the contract, the court will seek enlightenment in previous dealings between the insured and the insurer or its agent, in

statutory provisions and administrative regulations, in usages of the insurer and of the insurance business, in usages of the insured and of persons in similar situations, and in the authority of the insurer's representative.[1]

Under the *parol evidence rule*, once the contract is embodied in writing, evidence is not admissible to show that its terms are different from the written (or printed) provisions. But a subsequent oral agreement to amend the contract is generally enforceable.

In making an oral agreement, certain points must be expressly covered: the name of the insured, the name of the insurer, the amount of insurance (unless the contract is written without amount as in workmen's compensation insurance), and the term of the contract. If an agent represents several insurers and there is no specification by the insured or the agent of the insurer(s) with which the insurance is effected, there will be no coverage. The agent may, however, choose the insurer by communicating its name to the insured or by some act, such as making a note, clearly indicating his intentions. The contract becomes effective from the time that the insured and the insurer (or its authorized representative) have agreed on all essentials, including intimation to the insured that he is covered or will be as of a specified time.

Oral contracts should be used only in an emergency. A binder, or preferably a complete written contract, should be obtained in advance of the inception of the contract, or as soon thereafter as practicable.

STANDARDIZATION

Fortunately for the consumer, insurance contracts are highly standardized as a result of statutory or administrative directives, voluntary agreement, or customary practice. Otherwise choosing among the policies issued by thousands of insurers would be extremely difficult.

In most states the standard fire policy, which is the foundation for all fire-insurance contracts, is prescribed word for word by statute.[2] All insurers, domestic or foreign, writing fire insurance in those states must use the prescribed policy. Consequently, (1) the insured need not consider differences in policy language when selecting an insurer, (2) all insureds are subject to the same treatment, (3) policy conflicts do not arise when two or more insurers are required to provide the necessary protection or become involved in the

[1] For further discussion, see Patterson, *"Essentials of Insurance Law,"* pp. 81ff., and quotation on pp. 130–131 of this text.

[2] The fire-insurance contract always includes this statutory policy plus at least one form which varies with the type of property insured. The forms are not prescribed by statute. Forms for most types of property may be standardized for insurers using the services of a rating bureau or by a state-insurance-department directive.

same loss, (4) court interpretations of the contract become more meaningful, (5) insureds and insurance agents save time and energy in contract analysis, and (6) loss experience can be pooled for rate-making purposes. On the other hand, (1) desirable changes may be delayed because these can be accomplished only by revising a statute, (2) a contract that survives the legislative process may not be the best one, (3) the policy designed to meet the needs of the average insured may not meet the needs of many insureds, and (4) the advantages of experimentation and competition are lost.

In some states use of a standard fire policy is made compulsory because of a directive from the state insurance department. The effect in practice is about the same as if there were a statutory policy.

A less restrictive statutory approach is the use of statutory standard provisions under which the state prescribes certain important provisions but insurers can change the wording so long as the revised provision is at least as liberal as the statutory provision. This approach is best illustrated by life-insurance and health-insurance standard provisions. For example, all state laws prescribe that a life-insurance contract cannot be contested after one or two years on the grounds of concealment or misrepresentation by the applicant. Most states have adopted the 1950 Uniform Individual Accident and Sickness Policy Provisions Law with respect to health insurance. However, both life- and health-insurance contracts, particularly health-insurance contracts, contain numerous important provisions not covered by the statutes.

Most insurance contracts must be approved by the state insurance department before they can be used. Except in the rare case where this authority results in a directive that all insurers use the same form, the effect of this requirement is difficult to measure.

Voluntary standardization is common in many lines. To some extent, such as in workmen's compensation insurance and automobile insurance, one of the original incentives for voluntary agreement was to make statutory or administrative action unnecessary. The voluntary products are generally known as "standard-provisions" contracts. All insurers using these contracts provide the same basic protection but they have some flexibility with respect to the exact language and the arrangement of the provisions. These contract provisions are usually developed by rating bureaus, which also develop a common price for the product. In only one instance—workmen's compensation—has this method developed complete standardization. In the past there was a high degree of standardization in automobile insurance, but increased competition in recent years has resulted in a more diversified set of products.

Other forces favoring standardization are the tendency of businessmen to produce a product that is not too different from that of their competitors and a hesitancy to experiment with new phraseology that may expose them to

new risks of interpretation. On the other hand, competition also favors some product differentiation, and insurance contracts are seldom completely standardized. The degree of standardization varies among lines with workmen's compensation insurance being the most highly standardized field and marine insurance the least. Normally the insurance buyer can expect some product differentiation but his understanding of the contract issued by one insurer will have a high transfer value in understanding the contracts issued by other insurers.

STRUCTURE OF THE INSURANCE CONTRACT

An insurance contract, whether it consists of a policy plus a form or the policy only, contains certain provisions that can be classified as (1) declarations, (2) insuring agreements, (3) exclusions, or (4) conditions. In many property- or liability-insurance contracts the provisions are grouped into these four categories and labeled accordingly, but in other lines the provisions must be rearranged to achieve this grouping. In a few instances the existing arrangement is difficult to defend on logical grounds.

Declarations[3]

Declarations are statements by the insured, on the basis of which the insurer issues its contract. They may be formal but unsigned, as in the case of the automobile-insurance contract, of which they are made a part. They cover here such items as the occupation of the insured, a description of the automobile, and the use (say, pleasure and business) to which it will be put. They may be formal, signed, and made a part of the contract, as in life insurance, where they cover such matters as the age of the insured, his present and past state of health, his occupation, and his intentions as to certain specified activities. Or they may be informal and to some extent implied, as in fire insurance, where the contract usually rests on an oral agreement between the insured and the insurer, subject to the law of warranty, representation, and concealment, formalized to some extent in the "description of the property" written into the contract.

The purpose of the declarations is to give the insurer sufficient information to enable it, with information from other sources, to issue an appropriate contract at a proper price.

[3] The term *declarations* is here used as applicable to all kinds of insurance, though the technical terms vary.

Insuring Agreements

The primary class of provisions distinguishing one contract from another comprises the insuring agreements defining the perils insured against, the services promised, the losses covered, the amount (limits of liability) of the insurance, the parties to the contract (insurer and insured), the interest or property insured, the term of the contract, and the rights (if any) of third parties not named as insureds. For example, John Doe might be insured by the Plympton Insurance Company against loss due to claims for damages on account of bodily injury caused by accident occurring during the term of the contract and arising out of the ownership, maintenance, or use of a specified automobile. A limit of $10,000 might be put on the damages payable by the insurer to any one claimant involved in a single accident, and of $20,000 on the total damages payable to all claimants in a single accident. The insurer might promise to investigate claims, negotiate settlements, and, if necessary, defend actions at law brought to enforce such claims. Third persons driving the automobile with the named insured's permission might be defined as insureds, and persons alleging injury might be given a direct right of action against the insurer.[4] A life insurer may promise to pay a stated amount to designated beneficiaries upon the death of the insured. A fire insurer may promise to pay the actual cash value of property damaged or destroyed in a fire up to the insurable interest of the insured person or persons and subject to the policy limit.

Exclusions

It is probably safe to say that no insurance contract covers all loss from the perils named in the insuring agreements. Even life insurance, which most nearly approaches this ideal, excludes death by suicide during the first 1 or 2 years of the term of the contract and may, in unusual circumstances, exclude other causes of death. The automobile-liability-insurance contract may not apply to liability assumed under contract by the insured, to liability incurred under a workmen's compensation law, or when the automobile is used for certain specified purposes. Fire-insurance contracts exclude fire losses caused by war. Other contracts exclude certain sorts of property or do not cover under specified circumstances.

Many exclusions may be nullified by endorsement, though some are absolute.

[4] No attempt is made in this chapter to give an exact statement of the provisions of the automobile-liability-insurance contract, which is considered at length in Chapter 18.

Exclusions of perils, persons, property, or situations as not covered by the insurance contract may have any one or more of three purposes: (1) drawing lines between the coverage of the contract and that afforded by other contracts, (2) making exceptions that may be covered under the contract but only after consideration by the insurer and/or on payment of additional premium, or (3) making exceptions that the insurer regards as uninsurable.

Exclusions of the first sort are common. An example is the exclusion of explosion of steam boilers from the coverage of explosion insurance, since boiler insurance is a specialized line with its own special contracts. The second sort is also common, but the basic reasons for it vary. The insurer may feel that the problems involved are such that only after careful examination will it be practicable to determine whether the exception should be covered—to what extent, and at what rate of premium. Coverage of liability assumed by the insured under contract is an example; the extent and nature of such liability may be such as to carry with it a very high probability of loss or practically none at all. This type of exclusion is sometimes made in order to keep the cost of insurance within practical limits but give the insured who is willing to incur higher expense an opportunity to extend his coverage. The insurer may broadly protect itself by excluding coverage "while the hazard is increased" or may exclude certain things that are regarded as tantamount to an increase in hazard, such as the employment of an automobile, the use of which has been described as "pleasure and business," 'as a public or livery conveyance," or the operation of the automobile outside the United States and Canada.

Among the most common exclusions, regarded as uninsurable under many types of contract, are those of loss due to hostilities or warlike action, to which is now being added "any weapon of war employing atomic fission or radioactive force"; nuclear-energy hazards in general; insurrection; and orders of civil authorities (unless to prevent further loss by reason of a peril insured against). In determining what situations it considers to be uninsurable the insurer considers the characteristics of an ideal insurable risk outlined in Chapter 5 and the degree to which this situation would cause the insured risk to depart from each characteristic. For example, warlike action is likely to affect many persons at the same time, thus violating the independent-exposure criterion. In other cases the loss may be too indefinite as to cause, time, place, or amount, or the expected loss may be too high or too difficult to determine. Intentionally caused losses are excluded not only because losses should be accidental from the viewpoint of the insured but also because this exclusion states explicitly what public policy requires. Insurers vary, of course, in their judgment concerning what is uninsurable.

Some exclusions merely clarify what should be apparent from the insuring agreement. For example, the fire-insurance policy excludes losses caused by

riot unless fire ensues, in which case it covers the fire loss only. If this exclusion were omitted, the coverage would not be affected because a riot is not a fire, and only fire is mentioned in the insuring agreement of the statutory policy.

No attempt is made here to list all exclusions common to more than one type of contract. The purpose is to point out the universal existence of exclusions, the sort of exclusion to look for, and the necessity that both insurer and insured (particularly the latter) be aware of what is *not* covered by any insurance contract with which they are concerned. Only careful study of the individual contract will make this clear.

Conditions

A *condition* is a provision in the contract, compliance with which by the insured is essential to enforcing his rights under the contract. In those contracts that group provisions under this heading, the miscellaneous clauses described below are also included.

Insurance contracts bristle with conditions, some of which are found in the three sections of the contract already described. For example, the insuring agreement and the exclusions define the peril, the occurrence of which is the most important condition. In the declarations section of an automobile policy the insured may warrant that his car will be principally garaged in a certain city. These conditions are largely directed toward two objects: (1) exempting the insurer from liability for payment of loss if the probability of loss is increased, and (2) protecting the interest of the insurer by requiring the insured to furnish timely information and to cooperate with the insurer in the adjustment of losses.

Failure to observe conditions may deprive the insured of the insurance on which he relies. It behooves him to give careful attention to meeting all requirements of the contract, particularly where failure will automatically suspend or avoid the contract or where active compliance must be on his own initiative. A typical condition of the first sort is a warranty that a device protecting against loss will be properly maintained, or a provision that the insurance will be suspended if the premises are vacant or unoccupied beyond a specified period. Of the second sort is requirement of immediate notice of loss or of an accident that might result in loss, or provision for a binding appraisal of the loss on demand of the insurer.

While detailed compliance with the conditions often is not insisted upon, and substantial compliance may be considered sufficient in court, the insured disregards them at his peril. An overzealous adjuster, one who suspects fraud, or a not too scrupulous insurer may invoke them.

Signature Clause

Every contract provides in due form for signature by the insurer, usually a printed signature of one or more of its principal officers, effective when countersigned by an agent or other representative.

Miscellaneous

Contracts will also contain a variety of provisions that do not readily fall into any class and that are useful but not essential. Such are provisions against waiver, for cancellation, limiting the period within which suit may be brought by the insured, granting options to insurer or insured, specifying the time within which loss will be payable, limiting the insurer's liability if there is other insurance, or specifying the rights or obligations of third parties.[5]

Special Clauses for Certain Insurers

In the case of certain types of mutual, reciprocal, and fraternal-order insurer,[6] the contract is required by law to contain specific provisions relating to (1) the insured's right to vote at an election of the insurer, (2) his liability to assessment, if any, or (3) his right to participation in the earnings or surplus of the insurer, and the manner of their apportionment and distribution. These provisions are necessary, as the insured acquires rights and assumes obligations in addition to those of the insured generally in relation to his insurer. Sometimes, also, there are special provisions in the charter of an insurer which have an important bearing on its contracts. Clearly, these should come to the attention of the insured, and generally it is required that they be printed in the policy. In some cases, if these provisions restrict the benefits of a standard form, they are required to be made conspicuous, by the use either of a specified size and style of type, of red ink, or of both.

ENDORSEMENTS

In general, *endorsements* or *riders* added to the basic contract supersede any provisions in the contract with which they are in conflict. In particular, handwritten or typewritten endorsements are so construed. Endorsements usually represent a later agreement of the parties or are more particularly related to

[5] The last type of provision is essential to contracts written for the benefit of third parties.

[6] The different types of insurer are discussed in Part 3.

the risk insured than is the basic contract. They must themselves be clear and properly made a part of the contract if they are to be enforced.

Endorsements serve many purposes. For example, they may increase or decrease the scope of the protection, transfer the protection to a different insured, change the location of insured property, excuse the insured from some condition in the contract, change the amount of insurance, change the rate, or, as in the fire-insurance contract, be necessary to complete the contract.

BINDERS

Not infrequently an agreement is reached that a policy is to be issued and will be accepted, but the insured desires evidence, before the policy can be issued, that the insurance has been effected. The issuance of the contract may be delayed because (1) although the agent can bind the insurer, the contract must be prepared at the insurer's home office, (2) the insurer must gather more pricing information to process the contract, or (3) the insurer is not prepared to commit itself to more than temporary insurance and to the expense of preparing a formal contract without considering more underwriting information. In such cases it is customary for the representative of the insurer to issue a memorandum slip showing the risk to be covered, the date from which the policy is to be effective, the name of the insured, and the amount. The memorandum, a temporary contract of insurance, is a *binder*. Should loss occur before issuance and delivery of the policy, the insurance is recognized by the insurer as though the policy had been issued. Usually the binder covers only for a limited period and is subject to stated provisions for cancellation. Although insureds should pay a premium for the protection they receive under the binder even if they decide to cancel the protection before the policy is issued, they are seldom asked to pay in such an event. Some dishonest insureds, agents, and brokers have secured free insurance in this way.

Binders may also be used when the insured's need for protection is much less than a year.

The following statement is applicable both to oral contracts of insurance and to binders:[7]

> Anyone who reads a formal policy of insurance can readily see that to embody all of its terms in an oral agreement would require a lengthy conversation. Men living in a slow-moving civilization might have the patience to repeat the entire rigmarole, word for word. The speed of American business is geared too high for such dilatory procedures. Hence, if oral contracts, or even informal written contracts of insurance,

[7] Edwin W. Patterson, "Essentials of Insurance Law," pp. 87–88.

are to be made at all, many of the terms and conditions of the contract must be supplied by *implication.* Two important questions thus arise. What are the sources of such implication? What are the limits to such implication, i.e., what terms or elements of the contract must the parties *specifically mention,* if the agreement is to be sufficiently definite for legal enforcement?

The sources from which courts will draw the terms not mentioned in an informal agreement of insurance may be grouped under five heads: (1) previous dealings between the insured and the insurer or its agents;* (2) statutory provisions of the state in which the contract is made and administrative regulations made pursuant to such statutes; (3) usages of the particular insurer and of insurers in general; (4) usages of the insured and of those engaged in a similar occupation, trade, or activity; (5) the authority of the insurance agent to act *for the insured.*

* In case of an agreement between client and brokers, previous dealings between these two.

Because of the long-term nature of the life-insurance contract and the absence of cancellation provisions, life-insurance agents do not have the authority to bind coverage. However, if the applicant submits the first premium payment with his application, he usually receives a binding receipt under which it is agreed that the insurer will judge his insurability as of the date of his application (or perhaps the medical examination), and that, if he is insurable as of that date, his protection will be made retroactive to that date.

RENEWALS

In general, insurance contracts are renewed by the issuance of a new complete contract form, with such amendments as may be agreed upon by insurer and insured. However, this is not always the case.

Renewal Certificates

To some extent renewals are effected by the issuance of certificates continuing the coverage of the contracts for a period beyond that of the original contracts. Practices vary greatly between lines of insurance, insurers, and localities. Renewal certificates simplify renewals where there is little or no change in the contract from period to period.

Continuous Contracts

Insurance contracts may be written for a period to continue until canceled or as long as periodic premiums are paid. Such contracts have long been written in the fields of marine insurance, life insurance, and disability insur-

ance. More recently they have been adopted to some extent elsewhere, particularly in the automobile-insurance field, where many insurers are offering a 6-month contract which may be continued by timely payment of the premium.

QUESTIONS

1 Green purchases a windstorm-insurance policy by phone. Has he entered into a legally valid contract? If so, what are the terms of the contract?
2 Billings telephones Holt, an insurance agent, and says, "Insure my house against fire for $10,000." Holt says, "You are covered" and makes a note to place $5,000 with the Kingston Insurance Company and $5,000 with the Pembroke Insurance Company. Is Billings insured? If so, and a loss occurs before the contracts are fully made out, what are the terms of the contracts?
3 Would you favor a statutory automobile-insurance contract? Why or why not? If not, what method of standardization, if any, would you prefer?
4 Distinguish between a binder used in property and liability insurance and a life-insurance binding receipt.
5 Jones wishes that he could buy an automobile-physical-damage-insurance policy without any exclusions. Is this likely to be possible? Would it be desirable?

11
CONTRACT ANALYSIS

In analyzing an insurance contract, an insured is usually interested in (1) what situations are covered under the contract, (2) how much the insurer will pay if the situation is covered, and (3) what rights and obligations he acquires following a loss. The purpose of this chapter is to provide a framework for such an analysis. A by-product of this discussion will be an analysis of certain principles and provisions that are common to many, if not all, contracts.

SITUATIONS COVERED

To determine what situations are covered under an insurance contract it is necessary to investigate the covered (1) perils, (2) property or sources of liability,[1] (3) persons, (4) losses, (5) times, and (6) locations. This investigation will involve, first, a careful reading of the declarations, the insuring agreement, the exclusions, and the conditions. In many instances, however, it will also be necessary to consult state statutes, court decisions, and (less often) rulings of the state insurance department.

Perils Covered

Insurance contracts can be classified with respect to the perils covered as all-risks contracts or as named-perils contracts. The former type of contract typically states in its insuring agreement that it covers against "all risks of loss or damage . . . except as herein provided." It then lists any exceptions or exclusions that modify the all-inclusive statement quoted. Any loss not excluded or coming within the purview of the exceptions is covered. The insured may learn, by reading and understanding his contract, exactly what is covered. The named-perils contract, on the other hand, states the perils,

[1] This category does not apply to life- and health-insurance contracts.

loss by which is covered. Loss by any perils omitted, whether by design or otherwise, is not covered. Reading the contract does not reveal explicitly what perils are not covered—if other perils are beyond the knowledge or imagination of the insured, he does not know what is *not* covered.

All-risks contracts, therefore, are advantageous in that they enable the insured to reduce the number of contracts he must administer, to consider explicitly all of the hazards to which he might be exposed, and to avoid overlaps among the several named-perils contracts that might be required as an alternative for an insured desiring protection against many perils. On the other hand, the insured may not want or need protection against some of the perils included in the all-risks contract. A life-insurance contract and many of the newer property-insurance covers are all-risks contracts. Fire-insurance and theft-insurance contracts illustrate the named-perils approach.

Perils Defined. In order to determine what situations are covered under a named-perils contract or not covered under an all-risks contract, the perils named in the contract must be defined. Sometimes the contract itself defines the covered or excluded perils. In other cases, court decisions or state statutes must be consulted to provide a definition or to clarify the definition contained in the contract. The scope of the perils specified in a named-perils contract is limited both by their definitions and by the exclusions that apply to them.

Chain of Causation. In many cases the peril causing a loss is not named in the contract but was set in motion by that peril. In many such cases the responsibility of the insurer depends upon whether the named peril was the proximate cause of the loss.

In the opinion handed down in a Connecticut case,[2] proximate cause has been well defined:

> The active efficient cause that sets in motion a train of events which brings about a result without the intervention of any force started and working actively from a new and independent source is the proximate cause.

Further in the same opinion:

> . . . where there is a concurrence of two causes, the efficient cause—the

[2] *Edgerton and Sons, Inc.* v. *Minneapolis Fire and Marine Insurance Co.*, 116 A 514 (1955).

> one that sets the other in motion—is the cause to which the loss is to be attributed, though the other cause may follow it and operate more immediately in producing the disaster.

While these statements may seem to lay down clear rules, there is considerable room for the exercise of judgment in their application and for additional concepts of proximity in space or time. No question arises if the peril reaches the thing insured, but as the primary cause becomes more remote, its quality as proximate cause becomes more questionable. It has been said that many cases turning on proximate cause must be decided by "judicial intuition."

In one leading case[3] the facts were as follows: The contract covered a canal boat against loss from, among other perils, fire. While the boat was lying in the harbor, a fire broke out beneath freight cars loaded with explosives. This fire caused an explosion, which in turn caused a fire that set off explosives stored in the freight yard. This last explosion caused a concussion of the air, which damaged the boat, about 1,000 feet distant. The court said that, to justify recovery under an insurance contract, the fire "must reach the thing insured, or come within such proximity to it that damage . . . is within the compass of reasonable probability." Recovery was denied, on the ground that fire was not the proximate cause of the loss.

In another case[4] that may well be contrasted with the Bird case, insulation was burned, causing a short circuit. As a result of the short circuit, increased demands caused a belt driving a dynamo to part, freeing an engine from load. The flywheel burst and damaged building and machinery at considerable distance from the fire and untouched by it. The insurer argued that the loss to building and machinery was too remote to be covered as a loss by fire, but the court said that, since there was an unbroken chain of causation with no intervening cause, the fire was the proximate cause of the loss, which was, accordingly, covered.

Questions of remoteness in time and the possibility of intervening causes arose in three similar cases. In each case, a wall of a building had been left standing after a fire loss and the wall fell and damaged an adjoining building after a lapse of 7 days, 38 days, and 4 months, respectively. Recovery was denied in the 38-day case, but allowed in the others.

The proximate-cause doctrine, however, does not reveal all of the situations in which the loss will be covered. For example, assume that a windstorm causes damage to a building, including the overturning of a furnace that in

[3] *Bird v. St. Paul Fire and Marine Ins. Co.*, 224 N.Y. 47 (1918).
[4] *Lynn Gas and Electric Co. v. Meriden Fire Ins. Co.*, 33 N.E. 690 (1893).

turn causes fire and smoke damage to what remains of the building. The proximate cause of all these losses is the windstorm, but a fire-insurance policy would cover the fire and smoke damage that followed the windstorm damage. The chain-of-causation concept is consistent with this finding. According to this concept a chronological sequence of the perils involved is first constructed. Damage caused by any perils named in the contract is covered, as well as any perils set in motion by these named perils, unless an exclusion in the policy would require a different interpretation. For example, if a war causes explosion damage followed by fire damage, the fire damage is not covered because fires caused by wars are specifically excluded.

Property or Sources of Liability Covered

The property covered under a property-insurance contract may be defined on a specific or a blanket basis. Although the boundary line between specific and blanket coverage is somewhat vague, the concept can be illustrated by two extreme examples. A specific contract may state that it covers a described painting, automobile, piece of machinery, or building. A blanket contract may declare that it covers all personal property or buildings at three locations. An intermediate position might be the coverage of all finished goods at a named location. Sometimes a contract provides blanket coverage with respect to some items and specific insurance with respect to others.

Blanket coverage possesses advantages and disadvantages that are similar to all-risks contracts. Flexibility is a key attraction. Even though the insured purchases less insurance than the value of the blanketed property, he may be able to collect the full amount of a loss to a particular kind of property although this may represent only a partial loss to the total blanketed property. On the other hand, insurers usually charge for this flexibility through increased premium rates, certain contract provisions, or underwriting requirements.

Property-insurance contracts also commonly exclude certain types of property even when the property covered is fairly specific.

The contract may include only that property in which the insured has an ownership interest or it may include property for which he may be responsible in some capacity such as a bailee.

Liability-insurance contracts may cover all sources of liability not specifically excluded (in which case they are usually called comprehensive-liability-insurance contracts) or they may name certain covered sources of liability. For example, they may name premises-operations liability, elevator liability, and product liability, or they may state that all liability is covered except that arising out of the ownership, maintenance, or use of an automobile and some other sources. Contracts that specify the sources covered are, of course, also subject to excluded sources.

Persons Covered

A property-insurance contract may cover only the insurable interest of the named insured's property. In the latter instance these other persons are such as his legal representatives, his employees, guests, customers, or secured creditors or his family. These other persons may be covered with respect to losses to their own property, thus increasing the scope of the property included under the contracts, or they may be covered only with respect to the named insured's property. In the latter instance these other persons are protected against subrogation actions.

Liability-insurance protection may similarly be limited to the named insured or extended to include such other persons as his family, his employees, friends he permits to drive his car, tenants who occupy a building he owns, or distributors who market a product he manufactures.

Health-insurance contracts usually provide benefits for the person whose health is insured. Life-insurance contracts pay benefits to the persons named as beneficiaries.

Assignments. The effect of an assignment of a contract to someone else has been discussed on p. 108. In addition it should be noted that in most states the assignee acquires only the rights of the assignor, which may be nil because of breaches before or after the assignment. By its consent, however, the insurer everywhere waives any defenses of which it may have notice at the time of giving it.

These rules apply only to the assignment of the *contract*, to the substitution of one insured for another. The right to collect a *claim* under the contract may always be assigned without consent of the insurer, whether after a loss or in anticipation of a loss that may occur. The insurer is liable for payment to the assignee of a valid claim after having received valid notice of the assignment. The assignee does not become a party to the insurance contract and may collect only what is primarily due to the insured.

Special Protection for Secured Creditors. Because of the pitfalls associated with assignments, secured creditors have been accorded special treatment under standard mortgage clauses and loss-payable clauses used in connection with financed automobiles. The most important contribution of these clauses is to grant the secured creditors immunity from the breaches of the owner of which they are unaware.

[5] The standard mortgagee clause is discussed on pp. 170–172.

Losses Covered

Property-insurance contracts cover direct losses or certain types of consequential losses. Direct losses occur because the insured has to replace or repair property that has been damaged or destroyed or that has disappeared. Consequential loss insurance specifies the type of indirect loss that is covered, such as the loss of rent from a property rendered untenantable for a specified period, the loss of net profits and the expenses that continue while a business is shut down for repairs following a covered accident, or the loss of a valuable lease that can be canceled in the event of a major loss to the property.

In addition to paying settlements or court or statutory awards to the claimant, liability-insurance contracts provide certain supplementary benefits such as investigation of the claim; negotiation and, hopefully, settlement with the claimant; defense of the suit, if this proves necessary; payment of premiums on bonds and of court costs that may be incurred in connection with the claim; and payment of expenses incurred by the insured in cooperating with the insurer. Some contracts include a medical-payments section under which medical expenses incurred by certain persons are paid without regard to the insured's liability.

Health-insurance contracts cover either a loss of income caused by the insured's disability or medical expenses. Contracts may limit the types of medical expenses covered. Life-insurance contracts simply pay a specified amount upon the death of the insured.

Times Covered

The time of inception of the contract is specified, usually as of a certain date, or date and hour, standard time, at the address of the insured or at the location of the risk. Hour of inception is often 12:01 A.M. or 12 noon; if only the date is specified, the time would be the beginning of the day at midnight. Conditions on the policy becoming effective may be imposed, as by a provision that the premium must have been paid on or before the date (and hour), but unless such a condition is imposed, mere nonpayment of premium does not preclude inception. Inception may be dependent on an event, such as the departure of a ship or the award of a contract to a successful bidder.

The time of termination of a contract is usually specified in much the same fashion, but while a time of inception must always be specified, a contract may continue in force indefinitely.

Cancellation. An insurance contract may be canceled only by mutual agreement, based upon a new consideration, of the parties to the contract, unless it

makes provision otherwise. It is usual to make such provision, permitting the insured to cancel by giving written notice to the insurer stating when he desires cancellation to be effective, and permitting the insurer to cancel by (usually) 5 or 10 days' advance written notice to the insured. Where the advance notice must be *received* by the insured, it allows him time to rearrange his insurance affairs in the light of the cancellation, in particular to secure insurance to replace that canceled. But many contracts provide that "notice" shall mean *mailing* of the notice. The time necessary for transmission may reduce or eliminate the time available to the insured. It is conceivable that "notice" might arrive only after cancellation had become effective.

The question of what constitutes receipt of notice where the insurer is required to give notice has frequently been before the courts. A communication sent by mail is presumed to arrive at its destination in the normal course of the mails, but this is a rebuttable presumption that may be overcome by credible evidence. The notice must be so prepared as to *be* a notice. An insured who failed to open an envelope bearing the name of an insurer other than the one with which he had contracted and containing a notice of cancellation by the latter was not considered to have received the notice. In the absence of any specified hour the required period of advance notice runs from midnight of the day on which notice is given.

The most effective method of giving notice is by delivery to the insured in person, an acknowledgment of receipt being signed by him. Notices are sent by registered mail, by first-class mail receipted for by the post office, and by wire, but in all these cases proof is more difficult.

Ordinarily provision is made for return of premium on a *pro-rata* basis if the insurer cancels, i.e., the premium will be reimbursed to the insured in the proportion of the original premium that the unexpired part of the policy term bears to the term originally contracted for. If the insured cancels, the return is made on a *short-rate* basis; i.e., the amount returned will be somewhat less. Typical percentages of the original premium charged to the insured for coverage on cancellation of a 1-year policy are shown in the following table:

Days of coverage	Short rate	Pro rata	Difference
1	5	0.2739	4.7261
30	19	8.2182	10.7818
60	27	16.4364	10.5636
90	35	24.6546	10.3454
180	60	49.3092	10.6908
360	99	98.6184	0.3816

The difference in bases for return of premium is justified. If the insured is ready to abide by his contract, he should not be penalized if the insurer decides to discontinue it. But if the insured cancels he should pay whatever premium is proper for the length of time during which he has had protection. The insurer is subject to certain overhead expenses, regardless of the length of the contract term, and the cancellation itself gives rise to some extra expense. That the principle of lower rates per day for longer periods is recognized in insurance is evidenced by the lower charge per year as the original contract term lengthens. The rate for a 3-year contract may be 2.7 times the annual rate; for a 5-year contract, 4.4 times the annual. Another justification for the increased charge is the fact that the insured may have been subject to greater risk during the expired portion of the contract period.

Noncancellable Contracts. Some contracts make no provision for cancellation, notably those of life insurance, some disability-insurance contracts, and some marine-insurance contracts.

Special Provisions. Some contracts are cancellable only by the insurer; some, when canceled by the insured under special circumstances, call for pro-rata return of premium; some are cancellable only on notice to public authorities; and in at least one case, cancellation may be appealed to a state board.

Locations Covered

Some insurance contracts provide protection only if the loss occurs at a specified location; others cover all locations anywhere in the world that are not specifically excluded.[6] Between these two extreme treatments of the locations covered there are numerous other possibilities. Policies may, for example, cover losses at any one of a number of specified locations, at specified locations plus any new locations acquired by the insured, or anywhere within the United States and Canada that is not specifically excluded. Sometimes the policy provides less protection against losses incurred at certain locations.

Special Conditions

Some conditions that determine whether a given situation is covered may not fall logically into any of the six preceding categories. For example, the fire

[6] Insurance that covers property located anywhere within a specified area is called *floating insurance.*

policy suspends coverage while there is an increase in the hazard within the knowledge or control of the insured. It is usually more convenient and more logical to group these provisions under a separate category.

AMOUNT OF RECOVERY

Many of the provisions that affect the insured's recovery in connection with a covered loss have already been discussed on pp. 109–114 in connection with the concept of a contract of indemnity. They are the provisions dealing with (1) the measure of the loss, (2) insurable interest, (3) other insurance, and (4) subrogation. Consequently in this section we are concerned only with certain other provisions affecting the amount of recovery such as (1) the policy limits or the amount of insurance, (2) coinsurance clauses, and (3) deductibles.

Policy Limits

Policy limits or the amount of insurance may be specified in a variety of ways. The simplest approaches in property insurance are to cover all losses to covered property (1) up to a specified amount or (2) without limit. In the second instance, illustrated by automobile physical damage insurance, the policy limit is in effect the maximum possible loss to the property.

If the property covered includes many types of property or property at two or more locations, this insurance is called *blanket* coverage. Commonly different limits apply to different types of property or to the same type of property at different locations. For example, one limit may apply to a building, another to machinery, and still another to other contents, or one limit may apply to contents at one location with a different limit applying to contents at another location. The effect is the same as if a separate policy had been written with respect to each division of property having its own policy limit. This approach is called *divided* or *specific* coverage. The major attraction of blanket coverage over specific coverage is the flexibility it provides by making the face amount of insurance available to cover losses to any item covered under the contract. On the other hand, blanket insurance may cost more and be subject to more severe coinsurance (see below) and other restrictive provisions.

Another approach places a limit on a certain type of property but some subclass is subject to a lower *internal limit*. For example, one limit may apply to personal property but money losses may be limited to $100. This approach differs from the preceding case in that the internal limits are not

separate, independent limits. In the above example a $100 recovery against a money loss is charged against the over-all policy limit.

Separate limits can also be applied on the divided-coverage or the internal-limit approach to different perils, losses, or persons.

Finally, property-insurance limits can be classified according to whether they are fixed at the beginning of the policy period or vary in accordance with values reported periodically by the insured during the contract period. To illustrate, take the case of insurance on the contents of mercantile or manufacturing premises where the stock fluctuates in quantity and value. The fixed-amount approach would make it necessary for the insured to carry continuously an amount of insurance equal to the maximum value of his stock and pay premiums for more insurance than he needs at other times, or to take less and run the chance of a loss exceeding the insurance, or continuously to watch his stock and his insurance and add or cancel insurance (at the higher short rates) to keep it in step with his stock. These alternatives entail excessive expense, risk, or labor, or all of them. Hence, *reporting forms* have been developed. These forms provide for a provisional amount of insurance, or a stated percentage of the total concurrent insurance, with maximum limits set for property in each location. Provisional values and a provisional premium are agreed upon. The insured makes monthly reports of values exposed to loss at each location. At the expiration of the contract term the values in excess of those covered by specific insurance are averaged, appropriate rates applied, and the premium adjusted by the insurer, charging the insured premium on coverage in excess of the provisional amounts and refunding the premiums on amounts by which the provisional amounts exceed the actual. The principal advantage of these forms is that the insured is never over-insured or underinsured. The principal disadvantage is the effort involved in making the periodic reports.

Liability-insurance contracts usually limit the amount paid in awards or settlements for bodily injuries in two ways. The first states the maximum amount payable on account of the injuries sustained by one person; the second states the maximum amount payable with respect to one occurrence. For example, under a $50,000/$100,000 contract the insurer will pay no more than $50,000 for claims arising out of injuries to one person. If two or more persons are injured in the occurrence, the insurer is not responsible for more than $100,000 of their combined claims. If three injured persons have claims of $60,000, $10,000, and $30,000, respectively the insurer will pay $100,000. If each of the three claims had been $40,000, the insurer would pay $100,000. The limit with respect to property-damage claims is usually a stated amount per occurrence.

Single-limit-liability-insurance contracts are also available. A specified

maximum amount is payable per occurrence regardless of the number of persons involved and the mix of bodily injuries and property damage.

The supplementary benefits of defense, investigation, and the like are provided without limit (except for an internal limit on bond costs) and do not affect the amounts paid in awards or settlement.

Workmen's-compensation policies are unlimited with respect to the compensation coverage, the only limits being those in the relevant workmen's-compensation statute.

Health-insurance contracts usually pay stated periodic benefits upon the occurrence of total disability. A lesser amount is paid for partial disability. Different limits may apply to different types of medical expenses. Internal limits may apply to such items as daily room-and-board charges and surgical fees. The limits may be doubled if the person is injured in certain specified types of accident.

Life-insurance contracts (assuming no disability-income riders) have only one face amount payable upon death but they may pay some multiple of this amount if death is caused by "accidental means." The face amount may also increase or decrease over time.

Reduction of Amount. It has been the general rule, even in the absence of a specific provision, that the amount of an insurance contract covering physical property is reduced to the extent of any payment of loss, the premium to that extent becoming fully earned. For example, a loss of $1,000 is paid under a 1-year contract, the face amount of which is $5,000 and for which a premium of $50 has been paid. Dating from the time of the loss, the amount of insurance is $4,000, $10 of the premium has been fully earned, and $40 (in the absence of further losses) will become fully earned at the end of the year.

The tendency now is to provide, in a loss clause, for reinstatement of the insurance to its full amount after payment of loss, subject to limitations and to provisions for payment (or nonpayment) of additional premiums that vary from contract to contract. The following provisions from three contracts currently in use are illustrative: "Any loss hereunder shall not reduce the amount of this policy"; from a named-perils contract, "Loss hereunder shall not reduce such stated amount but the liability of this Company [insurer] shall not exceed such stated amount with respect to any one occurrence regardless of whether one or more perils contribute to the loss"; from an all-risks contract, "It is agreed that the sum hereby insured shall be reduced by the amount of any loss covered by this Policy . . . as of the date of the occurrence from which the loss arises. . . . However, the full amount insured

shall be reinstated automatically and a pro rata additional premium shall be payable from the date of the occurrence [to the termination date of the contract]."

Most liability-insurance contracts provide the same protection with respect to any occurrences during the policy period. A claim arising out of one occurrence does not affect the protection available for the next occurrence. The exception is the case where an aggregate limit does place a maximum amount on the claims paid in one year.

The question of restoration of policy limits is not relevant in life insurance. Health-insurance claims do not usually reduce the limits with respect to future claims, but some do limit the maximum amount collectible during a lifetime or after a certain age.

Coinsurance

As most commonly understood, coinsurance is an arrangement under which the insured bears a share of certain losses if the amount of his insurance is less than a specified percentage of the value of the property insured.[7] This arrangement and the reasons for it will be explained in the immediately following paragraphs.

A coinsurance clause reads as follows:

> In consideration of the rate and/or form under which this policy is written, it is expressly stipulated and made a condition of this contract that the insured shall at all times maintain contributing insurance on each item of the property covered by this policy to the extent of at least . . . . . % of the actual cash value at the time of the loss, and that failing to do so, the insurance shall to the extent of such deficit bear his, her or their proportion of any loss.
>
> If this policy be divided into two or more items, the foregoing conditions shall apply to each item separately.

Any percentage may be used, but 80 per cent is usual, and the illustrations of the application of the clause will be based on that percentage. Note that under the clause the reference "actual cash value" is the value at the time of the loss, not on the date the contract is purchased. Note also that in exchange

[7] Other clauses having the same general purpose are the "average clause," "contribution clause," "percentage coinsurance clause," "reduced-rate average clause," etc. See Prentiss B. Reed, "Adjustment of Property Losses," pp. 202–209. The term is used in health insurance to indicate a percentage-deductible feature.

for accepting the clause the insured receives (1) a form that would otherwise not be available or (2) a reduced rate.

Assume the following situation:

Value of insured property (one item) at the time of the loss	$100 000
Insurance	50,000
Loss	40,000

In this case the insured would have to carry $80,000 of insurance, if losses up to that amount were to be paid in full. He carries five-eighths of $80,000, and losses will be paid by the insurers (or insurer) only in that proportion. The insurers would here pay only $25,000 (five-eighths of $40,000), and the insured would bear $15,000 (three-eighths of $40,000).

If the loss were $80,000, the payment, applying the coinsurance clause, would be $50,000, but it would be $50,000 in the absence of the coinsurance clause since that is the amount of the insurance. If the loss were $90,000, application of the coinsurance clause would produce a limit of $56,260, but the insurers would be liable only to the extent of the amount of insurance, or $50,000. Generalizing, the clause has no effect when the loss is equal to or greater than the percentage of value specified. Further, if the insured carries the specified, or a higher, percentage of insurance, the effect of the clause is nil.[8]

Waiver of Inventory. If the loss is a small one, determining the value of the insured property at the time of the loss could involve more expense than the amount of the loss. Consequently the following clause, or one similarly worded, is often added to the coinsurance clause:

> In the event that the aggregate claim for any loss is both less than ten thousand dollars ($10,000) and less than five per cent (5%) of the total amount of insurance upon the property described herein at the time such loss occurs, no special inventory or appraisement of the undamaged property shall be required.

This clause merely excuses the insured from making the *inventory* specified. It does not waive application of the coinsurance clause.

Guaranteed-amount Clauses. In certain cases an amount of insurance (rather than a percentage of value) is used in a coinsurance clause, or it is agreed

[8] Further discussion of coinsurance and its applications will be found in chapters dealing with the various types of contract.

that a specified amount of insurance will satisfy the coinsurance requirement. By the use of such a provision the insured is not subject to the risk of being caught with an inadequate amount of insurance at the time of loss, even though he may have purchased a sufficient amount to satisfy the coinsurance requirements at the inception of the contract.

Why Coinsurance? In many foreign countries the coinsurance principle is made a part of the fundamental insurance law. In certain states of the United States, the application of coinsurance is prohibited or restricted by law. In most states the application of coinsurance is optional with insurers, and in some it is specifically authorized.

Coinsurance might appear to be a scheme to force insureds to carry insurance beyond their desires merely for the enhancement of the income of insurers. Why should one who has insurance in the amount of $5,000 on property worth $10,000 not be indemnified for any loss to a maximum of $5,000? A popular answer to this question, which is not without validity, is provided by a second question, which might be asked by the insurer: Suppose that a loss of $5,000 or less occurs; to which half of the value does it apply, the insured's or the insurer's? The basic reason for the application of coinsurance is found in the fact that the probability of loss is greater, in many forms of insurance, in the lower than in the upper brackets of value. Losses within the first $5,000 of value of properties worth $10,000 each will in the aggregate amount to more, often much more, than those parts of losses that exceed $5,000.

Figures on the distribution of fire loss given in the report of the Merritt Committee[9] are quite as cogent for purposes of illustration as when they first appeared. On a certain class of building the average experience per 100 fires and per $100 of value was approximately as shown at the top of p. 147.

Assuming one fire for each 100 buildings insured, 10,000 buildings would have produced 100 fires. If each building were valued at $1,000, the total value of the property would be $10,000,000 and the loss $9,160, or $0.0916 per $100 of value. If the full value were insured the rate would be $0.0916.[10] But suppose that only 10 per cent of the value were insured. The insurer

[9] *Report of the Joint Committee of the Senate and Assembly of the State of New York Appointed to Investigate Corrupt Practices in Connection with Legislation and Affairs of Insurance Companies, Other than Those Doing Life Insurance Business*, pp. 82ff.

[10] This rate would provide for losses. If rates were figured on the basis of a 50 per cent loss ratio (losses to premiums), the rate charged would be $0.18 (dropping fractions).

Loss	No. of fires	Average loss	Total
$10 or less	82	$ 2	$164
$10.01–$20	6	14	84
20.01– 30	3	25	75
30.01– 40	2	35	70
40.01– 50	1	45	45
50.01– 60	1	55	55
60.01– 70	1	65	65
70.01– 80	1	75	75
80.01– 90	1	85	85
90.01–100	2	99	198
Total	100	...	$916

would then pay, per $100 of value, losses of $10 or less in full and $10 on each of the remaining losses as follows:

82 losses of $10 or less	$164
18 losses exceeding $10	180
Total	$344

The losses paid on $10,000,000 of value would be $3,440; the insurance carried, $1,000,000; and the rate, $0.344.

Similarly it could be shown that the rate for 80 per cent insurance would be $0.1091; the insurer would collect $8,728, and the losses payable would be $8,728. But suppose that, although the insurer assumed that insureds would take insurance to the extent of 80 per cent of value and quoted a rate accordingly, insurance were actually taken out on each building to only 40 per cent of value. In that case the amount collected at $0.1091 per $100 of insurance would be $4,364. The insurer would pay $1,640 + $840 + $750 + $700 or $3,930 on losses of $400 or less and 7($400) or $2,800 on losses of larger amount. The total losses payable, therefore, would be $6,730.

Consequently a graded-rate system might be constructed by increasing the rate as the percentage of insurance to value decreases, but it would require valuation of all insured property and would not be adjusted to the value at the time of loss. Further, it would furnish a basis for controversy with every insured.

The coinsurance clause provides another route for achieving this type of rate equity. Rates are varied in accordance with the percentage specified in the coinsurance clause; the higher the percentage, the lower the rate. For

example, assume that in the previous illustration an 80 per cent coinsurance clause were endorsed on the policy. The rate would be $0.1091 per $100 of value. Insureds who carried insurance equal to at least 80 per cent of value would not be penalized by the presence of the coinsurance clause but they would pay the lower rate to which they are entitled. On the other hand, 10,000 insureds who carried insurance equal to only 40 per cent of the value of the property would be paid only in the proportion that the insurance carried bore to 80 per cent of the value of the property: 400/800, or 50 per cent. Settlement per $100 of value per 100 fires would be made as follows:

No.	Amount	Payments
82	$164	$ 82.00
6	84	42.00
3	75	37.50
2	70	35.00
1	45	22.50
1	55	27.50
1	65	32.50
1	75	37.50
1	85	40.00
2	198	80.00
Total		$436.50

The application of the coinsurance clause would reduce the amount payable to $4,365, the amount paid by the insureds.[11] This example indicates the manner in which the coinsurance clause justifiably protects the insurer. The insureds who carried insurance equal to only 40 per cent of the value of the property would be penalized because they were not entitled to the lower rate associated with the 80 per cent coinsurance clause. They should have secured a 40 per cent clause or paid a "flat" rate, the rate for a contract with no coinsurance clause.

It is possible, of course, to charge *all* insureds a flat rate for insurance without the coinsurance clause that will produce premiums adequate to cover all losses, but if that is done it means that those who carry full insurance are paying an excessive rate, and those who carry less than full insurance an inadequate rate. Where insured property is subject to fires that usually result in a large percentage of loss to value, and often in total loss, as in the case of unprotected frame buildings, the absence of the coinsurance clause does not work appreciable injustice. At the other end of the scale, the writing of the highest-grade "fireproof" buildings in protected areas without coinsurance

[11] $1 difference due to dropping two decimals.

would be extremely inequitable. It is sometimes said that not over 15 per cent of the value of a modern "fireproof" office building is subject to loss in any one fire, excluding conflagration losses. Owners who insured such a building for 15 per cent of its value would therefore receive in practically all cases the same payments of loss as would owners insuring for 80 or 100 per cent.

While the examples given have been largely from the fire-insurance field, the principle is applicable wherever there is a tendency for percentages of loss to value to be concentrated in the lower brackets. However, the principle is not generally applied in family insurance because of the problems of explaining coinsurance to the typical family, the probable lack of accurate appraisal information following a loss, and the small premium differentials that would be involved both relatively and absolutely.

Deductibles

Under a deductible clause the insured bears losses up to a specified amount. The insurer is responsible for losses in excess of this amount up to the policy limits.

Types of Deductibles. Deductibles assume many forms. First, they may apply to each item damaged, each accident or illness, or the total losses in a stated period. Second, the deductible may be a specified amount, a percentage of the loss, a percentage of the face amount of insurance, or a waiting period before disability income losses are paid or be determined in some other way. Expressing the deductible as a percentage of the loss differs from the other practices described above in that the deductible amount in dollars increases as the size of the loss increases. Sometimes a percentage deductible applies to losses after first subtracting a stated deductible amount; in other cases a percentage deductible is not permitted to exceed a stated dollar amount. Sometimes the deductible amount decreases as the loss size increases—for example, the insurer may agree to pay 125 per cent of the losses in excess of $100 or more until the deductible amount is reduced to zero, after which the entire loss is paid. The result is a $100 deductible for losses of $100 or less, a $75 deductible for a $200 loss, a $25 deductible for a $400 loss, and no deductible for losses of $500 or more. A related concept in some disability-income-insurance contracts (mainly workmen's compensation insurance) is a retroactive waiting period under which the waiting period is waived if the disability extends beyond a certain period. Still another type of deductible is a flat amount that decreases as the number of claim-free years increases. Third,

the deductible may apply to all losses covered under the contract or only to certain losses. For example, under an all-risks contract the deductible may not apply to losses caused by fire and several other specified perils. Fourth, the deductible may be a franchise, in which case the insurer pays all losses in excess of the franchise amount. For example, if the franchise is 3 per cent of the amount of insurance, the insurer under a $10,000 contract would pay nothing on losses of less than $3,000 but would pay the total amount of larger losses. This approach is used primarily in marine insurance.

Purpose. Deductibles are included in insurance policies primarily to reduce premium rates. They are most effective when the losses excluded by the deductible are relatively numerous. Deductibles are not used in life insurance because all losses are total losses. A deductible may also reduce the rates because the cost of adjusting small losses is relatively large (they may even exceed the dollar losses themselves). Finally, because the insured must bear the first part of the loss, the morale hazard may be lessened. This last reason may serve an underwriting purpose as well as a pricing purpose.

POST-LOSS RIGHTS AND OBLIGATIONS

Following a loss the insured has certain obligations to fulfill before he can collect from the insurer. He also has certain rights that he can enforce if he is not satisfied with the way in which the insurer is handling the claim. This final section considers the major contract provisions affecting these rights and obligations.

Notice of Loss

A requirement that the insured give the insurer immediate (often written) notice of loss is almost universally found in insurance contracts. In some types of contract notice of happenings that *may* give rise to loss is required, as for example, of an accident that may result in a claim for damages, or of the commencement of disability that may entitle the insured to benefits. In either case compliance with the requirement is a condition precedent to enforcement of the contract against the insurer. The insured should be particularly careful to familiarize himself with the exact terms of this requirement in each contract.

The word "immediate" means as soon as is reasonably possible. In some contracts the words "as soon as practicable" are used. The insured may not know that a loss has taken place, as in the case of a summer home burnt

during the winter when the owner is far away. Or he may be incapacitated and unable to take the action necessary to give notice.

What constitutes notice is sometimes spelled out in the contract. It may be stated that notice to the insurer's agent is notice to the insurer; telegraphic notice may be specified; certain particulars may have to be included in the notice. Notice to the police may be required.

Since the purpose of the requirement is to give the insurer timely opportunity to take whatever action it deems appropriate in the premises. knowledge of the loss or other occurrence acquired by the insurer from any other source exempts the insured from the requirement. The insurer may waive notice by negotiating with the insured concerning the occurrence or by dispatching an adjuster to investigate.

The insured should not rely on substitutes for notice in accordance with the terms of the contract, nor on what seems to be evidence of waiver. He should give notice and have evidence that he has given notice, as a preliminary to enforcing his contract.[12]

Proof of Loss

The burden of proof is on the insured or a third-party beneficiary to show that a loss has occurred, its extent, and the liability of the insurer to pay it. The contract often specifies the manner of filing proof of loss, the time within which it must be filed, and the information that it must contain. Unless the requirements are nullified or changed by statute, they should be strictly complied with. For example, the standard fire-insurance policy as used in most states requires the insured, on his own initiative, to file a proof of loss containing specified particulars within 60 days of the loss. Compliance with this requirement is a condition precedent to recovery from the insurer, and it is strictly enforced by the courts, though impossibility of meeting the requirement may, in some cases, excuse noncompliance.[13]

Examination Under Oath

Many insurance contracts provide that the insured shall submit to examination under oath. One contract typically provides that:

[12] The insured should note which provisions applicable after loss require him to act on his own initiative and which require action only on demand by the insurer.

[13] In New York State failure to file proof of loss under a contract covering loss or damage to property is a breach of contract only if the insurer has made a written demand for proof on the insured and has furnished suitable forms for making proof (Insurance Law, Sec. 172).

> The Assured[14] shall submit and so far as is within his or their power shall cause all other persons interested in the property, including any employees, to submit to examinations under oath by any persons named by the Company relative to any and all matters in connection with a claim and subscribe the same; and shall produce for examination all books of account, bills, invoices and other vouchers or certified copies thereof, if originals be lost, at such reasonable time and place as may be designated by the Company or its representatives and shall permit extracts and copies thereof to be made.

Such a provision is enforced by the courts, but:

1. The demand for the examination under oath must be made within a reasonable time after the fire [or other casualty] and within the time limited for the payment of the loss.
2. The demand for the examination under oath must be made by the company [insurer].
3. The company [insurer] must name the person who is to conduct the examination under oath.
4. The examination under oath and the production of papers must be at a reasonable place or point with respect to the place of fire [or other casualty].

Appraisal

To avoid the trouble and expense of court proceedings, insurance contracts often provide for *appraisal* of loss where insurer and insured fail to agree on its amount. The contract provides, with variations, that each party shall, on the written demand of either, select a *competent* and *disinterested*[15] appraiser. The appraisers select (or, on failure to do so, have selected for them) a competent and disinterested umpire. The appraisers then determine the amount of the loss and the actual cash value of the property at the time of loss, submitting their differences only to the umpire, the award of any two being sufficient. The appraisal is finally determinative of the amount of the loss and will be accepted by the courts as evidence.[16] It may be attacked only on the ground that the provisions for appraisal are not complied with; for example,

[14] "Insurance" and "assurance" have the same meaning, as do "insured" and "assured," "insurer" and "assurer."

[15] "Disinterested" here means not subject to the influence of personal advantage.

[16] Agreements to arbitrate legal questions, such as whether the insurer is liable for the loss, are illegal and unenforceable as ousting the courts of their proper jurisdiction, unless specifically authorized by statute. Appraisals are enforceable since they deal with questions of fact.

that appraiser or umpire was incompetent or interested. Gross error or fraud may be evidence of incompetence or interest.

While the contract provides for appraisal on the initiative of the insured, it is generally held that if the insurer does not enter the appraisal, the insured's only remedy is to sue to recover the amount of his loss, which he must establish. If the insured sues, as a result of such failure of the insurer to comply with the contract provision, the insurer is held to have waived its right to demand an appraisal. The insured is then in the same position as though there were no provision for appraisal in the contract.[17]

Options

Insurer. In contracts covering loss of property, the insurer usually reserves the right to exercise certain options in settlement of loss that are alternatives to the payment of the loss in money. Such options may be detailed, as in the following provision from the standard fire-insurance policy:

> It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

The purpose of these options is to enable the insurer to meet a claim that seems to it to be exaggerated. The first option may be useful if the percentage of loss to value is in dispute—it applies only to personal property and its exercise is often completely agreeable to the insured.[18] While the other options may be used, they are subject to two difficulties: that the insurer is not in the business of repairing, rebuilding, or replacing, and that the insured may contest the adequacy of the result.

The options may be expressed more simply by stating that "adjusted claims shall be paid *or made good*" (emphasis supplied). In the absence of any

[17] In an Ohio case, the Supreme Court of Ohio upheld the appointment of an umpire by a lower court on the insured's request, the insurer having failed to appoint an appraiser. An award was made by the insured's appraiser and the umpire. For discussion and report, see 44 ALR 2d, 841ff. The Minnesota standard policy provides for appointment of an appraiser by a judge on application of the party who has made an appointment, the other party not having done so within 20 days. Similiar provision is made for appointment of an umpire if the appraisers fails to agree on one. It would appear that provision should be made elsewhere for enforcement of the appraisal clause or that it should be, to the extent that it is unenforceable, removed from the contract.

[18] But the insured has no right to abandon his property to the insurer.

unqualified agreement to *pay*, "making good" would be sufficient as indemnity for loss.

Insured. The insured seldom, if ever, has any option as to the form that satisfaction of his claim shall take, except under contracts of life or health insurance, including under life insurance endowments and annuities. These options will be considered in Chapters 21 and 22.

Subrogation

The common-law right of the insurer to be subrogated to the rights of the insured to the extent of payment of claim is usually stated in contracts to which it is applicable.[19] Provisions may be added requiring the insured to cooperate in enforcing these rights, he may be required formally to assign them to the insurer, or he may be required to do nothing to prejudice such rights.

Cooperation of Insured

Provisions stating the duty of the insured to keep loss to a practicable minimum or to cooperate with the insurer in dealing with losses are found in insurance contracts. Their variety is such that example or summary seems not to be in order here. But the parties, particularly the insured, should be aware of the specific provisions applicable to contracts in which they are interested.

Payment of Loss

Provision for payment of loss within a specified period, typically 30 or 60 days, is usually made.

Suits Against Insurer

Limits of time before which or after which a suit against the insurer may not be instituted are usually included in the contract.

This is a general text and not a work of reference. The purpose is to cover

[19] I.e., contracts of indemnity. See pp. 109–114.

important underlying facts and principles and to direct the reader to the sort of information he should seek in further study. His sources will be specialized texts, reference books, and the contracts themselves.

QUESTIONS

1 Property is insured against loss, the amount of the insurance being $10,000. A loss of $3,000, covered by the insurance, occurs during the contract term. What is the amount of the insurance following payment of the loss?

2 To what extent can an insured determine, by reading an insurance contract, what it does not cover?

3 What are the reasons for short-rate return of premium on cancellation of an insurance contract by an insured?

4 A property valued at $100,000 is insured in the amount of $60,000 under a contract containing the 80 per cent coinsurance clause. A loss of $32,000 occurs. What amount is payable to the insured? What amount would be payable if the loss were $60,000? $85,000?

5 Certain types of building are practically never damaged to an extent greater than 25 per cent of value. Are insurers justified in requiring, for full payment of all losses not exceeding the amount of insurance, that an amount of insurance at least equal to 80 per cent of value be carried?

6 What should be the insured's first care after an event that may produce a loss under his insurance contract, and after doing what a prudent man would do to protect his property or otherwise keep the loss to a practicable minimum?

7 What must an insured prove in order to enforce payment of a loss by an insurer?

8 Distinguish between the effect of an 80 per cent coinsurance clause and of a 20 per cent deductible clause.

9 A truck crashes into a building, causing some industrial apparatus to malfunction. The malfunction causes fire damage, which in turn causes smoke and water damage. How much of this loss is covered by a fire-insurance contract?

10 Would you prefer blanket or divided coverage on the inventory at two retail stores operated by the same business? Why?

12
FIRE-INSURANCE CONTRACTS

Fire insurance originated in 1666 following a fire that destroyed a large portion of London. Until this time the only form of modern insurance in existence was ocean marine insurance, which is described in the next chapter. Today most businesses and families have some protection against fire losses under the contracts described in this chapter or under the broader contracts described in some of the succeeding chapters.

THE STANDARD POLICY

In the early history of fire insurance each insurer prepared its own contracts, and much fine print was sometimes used, making restrictive clauses difficult to read. Sometimes the insured, sometimes another insurer, or sometimes even the shrewd insurer that drew the contract, was the victim of this practice. From time to time efforts were made to secure the adoption and use of standard forms. Earnest efforts along this line were made by insurers at the meetings of the National Board of Fire Underwriters in 1867 and in 1868, but without success. In 1867, the Connecticut legislature enacted a law providing for uniform conditions, but the form was so unsatisfactory that it was repealed the next year.

Massachusetts, which has set the example of insurance reform in so many ways, was the first state to enact a law providing for a standard policy. This was done in 1873, and with minor changes, this policy continued in use until 1952. The policy was not liked by the insurers and was not generally adopted for use elsewhere.

Sentiment for a standard form was crystallized in New York, when an attorney, who was also a state senator, nearly ruined his eyes and temper trying to decipher the fine-print clauses and secure a proper settlement of the insurance on the building of the Buffalo YMCA. The reaction was not delayed by the fact that a fellow member of the Senate Insurance Committee had not long before been victimized through the fine-print provisions of an insurer's policy, though

the other insurers involved had made up that insurer's shortcoming. The result of an interesting lobbying and legislative battle was the enactment of a law calling upon the New York Board of Fire Underwriters to prepare and file with the Secretary of State a standard policy and standard modifying endorsements. This was done, and the policy became effective in 1887, though it is known as the 1886 policy. Many states adopted this policy, and it was used by many insurers in states not prescribing any standard form.

At the time of the San Francisco conflagration in 1906, no standard policy was prescribed in California, and difficulties arose in the settlement of losses in that disaster. Certain insurers flatly denied liability, because of special earthquake clauses in their contracts. A standard policy law was enacted by the legislature of 1907 but vetoed by the governor, who appointed a commission representing the various commercial interests of the state, including in the minority the insurers, to draft a standard fire-insurance policy. The insurance commissioner was appointed chairman. The policy recommended by this commission was adopted by the legislature of 1909 and was used in California until 1949. It was a revision of the New York form of 1886 and had some unique provisions, theoretically permitting a very flexible contract, but the adverse publicity of red ink and large type required for the use of certain optional restrictive clauses effectively prevented their general adoption by insurers.

The example of the California policy, which was considerably more liberal to the insured than the old New York form, led to a general agitation for revision of the old form and emphasized to insurance men the desirability of a nationally uniform policy. As insurance had been held not to be commerce within the meaning of the commerce clause by the Federal Constitution,[1] this revision could not be accomplished by federal legislation. In 1913, however, the New York legislature directed the Superintendent of Insurance of that state to request the National Convention of Insurance Commissioners to undertake the preparation of a new standard fire-insurance policy. This request was complied with, and the committee finally reported in 1917. The policy so prepared was adopted in New York, effective Jan. 1, 1918, and was later adopted in several other states either officially or by the insurers. It was, however, not made uniformly effective in all states, and all the policies mentioned above were used in one or more states as late as 1943. From early in the 1930's there was agitation by many interests for revision and simplification of the policy and for greater uniformity. But many, particularly the insurers and their counsel, feared the confusion that a new form might cause while going through the process of court interpretation.

[1] *Paul v. Virginia*, 8 Wall. 168 (1869). Reversed in *United States v. South-Eastern Underwriters Association, et al.*, 322 U.S. 533 (1944).

The National Association of Insurance Commissioners, in 1936, appointed a special committee to prepare a new policy. After 3 years of work, a form was submitted and approved by the association but failed of adoption in any state. Agitation continued, and a new policy was adopted in New York, effective July 1, 1943. This policy is now used in all but three states with little or no modification. In Massachusetts, Minnesota, and Texas the standard policies are based on and are similar to the New York form.

The following discussion will be based on the New York policy and its principal modifications by endorsement.[2]

Form of the Policy

The basic insuring agreement and the description of the property insured appear on the first page of the policy. On this page are found (aside from endorsements) all the data that distinguish the particular contract covering a particular insured from other contracts.

On the second page are the provisions that modify the basic insuring agreement. In lines 1 to 55 are found the provisions with which (in conjunction with any applicable endorsed provisions) the insured should familiarize himself in order to know what his coverage is and in order to maintain it. Lines 56 to 85 cover cancellation rights and the interest and obligations of a third-party mortgagee payee. The remainder of the policy is applicable only after a loss has occurred, but the insured should, from the inception of his insurance, understand the provisions applicable after loss in order to be prepared properly to make claim.

Basis of Issue

No formal application and no formal representations are required to be attached to the policy. It is the practice of owners of city property freely to permit inspection of premises by the underwriters' inspectors. Most cities require filing of plans and specifications of proposed buildings before building permits are issued, and these are available to the underwriters. Insurers have maps or other records that show the location and types of construction of buildings in urban centers, and information given by these is generally more accurate than the owner would be able to give. The need of promptly cover-

[2] It is assumed here as elsewhere that the reader will provide himself with specimen contracts, which may be obtained readily, either in the kits mentioned on pp. 105–106 or from individual insurers. For an extensive collection and explanation of endorsements, see the *Fire, Casualty and Surety Bulletins.*

ing property and keen competition for business have long since caused the issue of policies without written application to become the general practice.

It is, however, the privilege of any insurer to insist upon a written application before it will issue a policy, or upon the attachment of certain warranties to the basic contract. In some parts of the country it is the practice to require a written application for insurance on farm property, since there are no adequate facilities for otherwise obtaining the necessary facts.[3] The application is brought into the contract by attachment of a warranty referring to it. When underwriting results have been unsatisfactory, it has sometimes been suggested that a more general use of applications would be desirable, but the practice has not been adopted, nor does it seem likely to be.

Insuring Agreements

The name of the insurer appears at the head of the contract, and the subject of the first sentence is "this company," meaning the insurer whose name appears at the head. The insurer is bound by the signatures (usually facsimile reproductions) of its president and secretary to the attestation clause on the first page and requires countersignature by its authorized agent at the place where the contract is issued. The name of the insured is to be written in as the object of the verb "does insure" near the head of the contract and is followed by a description of the property insured. The insurance also covers the insured's legal representatives. Thus the policy covers an heir or executor under a will or a receiver in case of bankruptcy.

The policy is an *interest* policy—it covers whatever insurable interest the insured may have in the property described.

Perils Covered. The standard contract covers against "direct loss by fire, lightning and by removal from premises endangered by the perils insured against." The words "direct" and "fire" require definition.

A *direct* loss by fire includes those losses in which fire is the proximate cause, i.e., the loss is the immediate result of fire, as in the burning of a building, or which result from an unbroken chain of events, with fire as the primary cause of the events, as when fire causes a building to collapse, which in turn damages an adjoining building, though the latter may not be set on fire. It also includes, according to the chain-of-causation concept described on pp. 134–136, losses in which fire is not the proximate cause but was in turn set in motion by some other cause, such as, say, a windstorm or an explosion.

[3] Many insurers specializing in farm property are exempted from the statutory-policy law. Consequently farm property may be otherwise insured.

The term "direct" also states that only direct losses, not consequential losses, are covered.

Fire means ignition, but no degree of heat short of ignition comes within the coverage of the contract. The contract does not of itself limit the kind of fire, loss from which will be covered, but by common law two kinds of fire are distinguishable: *friendly* and *hostile*. Fire in its proper place is highly useful and is a friendly fire. Fire not so confined is dangerous and destructive and is a hostile fire. The contract covers only loss by a hostile fire. Hence, destruction of jewelry or other valuables that accidentally fall into a fire in the stove or on the hearth is not covered by the contract. If the fire rolls out of the grate across the hearth and onto the rug in front, its character is changed into that of hostile fire, and the loss is covered.

Mere heat is not fire, and damage due to scorching of paint by an overheated stove is not damage by fire within the meaning of the contract. There has been no fire except within the stove, and that is a friendly fire. If a pan of grease on the stove takes fire and, without igniting anything else, creates such a thick greasy smoke as to ruin paint that must be repaired, the resulting loss is caused by a hostile fire and is covered by the contract.

Location of Property. The hazard of loss by fire is in considerable measure a matter of location of the insured property. If a building is insured, its geographical location and its relationship to other risks are significant. Personal property takes on to some extent the hazard characteristics of the place in which it is located. Rates, contract terms, and acceptability of property for insurance are greatly affected by location, and the contract is intended to cover property only "while located or contained as described . . . but not elsewhere."

Under early contracts, when personal property was described merely as located or contained in a specified place, the courts were inclined to hold that the contract would cover it elsewhere, if its description implied customary use elsewhere. For example, it was held that carriages, insured as contained in a livery stable, were covered while in a repair shop some distance away, since the insurer should have understood that carriages would customarily be sent out for repair. But the words "and not elsewhere" clearly limit the coverage to the described location, though the description itself may be matter for disagreement.

Again it is to be emphasized that insureds and others concerned with the contract should see to it that the description of the property specifies its location with precision, and that extension of coverage is obtained for any location varying from that specified. The contract itself does provide that it will cover the property insured in the following manner:

> pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy. . . .

For example, if property at a single location valued at $10,000 is insured under a contract in the amount of $8,000, and parts of it valued at $5,000, $2,500, and $2,000 are "necessarily removed" to locations A, B, and C respectively, the property at A would be insured for five days in the amount of $4,000; at B, $2,000; and at C, $1,600. This provision (if he is conscious of it!) removes any temptation the insured might have to leave endangered property where it was originally insured and gives him an opportunity to readjust his insurance to afford coverage after the expiration of the five days.

Exclusions

Certain perils and types of property are excluded under the statutory policy. For example, losses caused directly or indirectly by war are excluded, as are losses caused by the order of any civil authority except when these authorities destroy the property in order to prevent the spread of a fire that would be covered under the contract. Money, securities, and similar property are excluded under this contract (but can be covered under the other contracts, such as the money-and-securities policy described on pp. 283–284). Bullion and manuscripts, an item that is difficult to value, are not covered unless specifically mentioned in an attached form.

Unless otherwise provided by endorsement, the insurer is not liable for loss occurring:

(a) while the hazard is increased by any means within the control or knowledge of the insured,[4] or
(b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days; or
(c) as a result of explosion or riot, unless fire ensue, and in that event for loss by fire only. [Lines 31 to 37.]

Item (a) is self-explanatory, though questions may arise whether the hazard *is* increased, and whether an increase is "within the control or knowledge of the insured." As to item (b) the following has been stated:[5]

[4] Under the laws of some states the insurer is liable for loss if the increase in hazard did not contribute to the loss.
[5] "Vance on Insurance," p. 860.

> A marked distinction between vacancy and lack of occupation has grown up. A building is said to be vacant when it is wholly and permanently deserted by its former tenant, with the removal of all his goods therefrom. But when the house is merely closed temporarily during an absence of the tenant, the furnishings remaining within, it is said to be "unoccupied." Thus, a house which has been shut up for the summer, with all of its furniture and other accessories of habitation remaining in it, is not vacant, but merely unoccupied, even though it may be tenantless for many months, and it has been held that a dwelling is not unoccupied during the temporary absence of the occupant.

Loss by explosion is covered if the explosion was caused by a hostile fire. If item (c) were omitted, the coverage would not be changed. Its only purpose is clarification, but unfortunately its presence tends to confuse the reader.

Limitations on Amount Recoverable

The standard policy includes several limitations on the amount recoverable by the insured in case of loss. The lowest limit applicable to a given case is the effective one. The following limits have been explained or are self-explanatory: (1) the amount of insurance afforded by the contract, (2) the actual cash value of the loss, and (3) the interest of the insured. Two other limits may require explanation.

(4) ***The "Without" Phrases.*** The intent of the contract only to *indemnify* the insured for a direct property loss is emphasized by the part of the insuring agreement which specifies that the insurer will not pay more than

> the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture. . . .

The first limit, "cost to repair or replace," is a common one, but the "without" phrases are characteristic of fire and allied forms of insurance.

Often, buildings that do not meet governmental requirements for the construction of new buildings are allowed to remain standing. But if they are damaged beyond a stated percentage (commonly 50), they must be razed and may be replaced only by superior, and more costly, construction. Similarly, repairs where demolition is not required may be regulated and a requirement

enforced that would involve putting the property in better condition than it was before the loss, as, for example, requiring noncombustible roofing to replace burned wooden shingles.

In these cases, the insured would be put to expense for demolition or removal of the remains of the old roof and, even though he improved his property, would be obliged to expend for repair or reconstruction more than it would cost exactly to replace what he had lost. But it is the intent of the standard policy only to indemnify him to the extent of the *direct loss*.

Loss due to interruption of business is a more common consequence of fire than is demolition or increased cost of construction. It consists of the net profits that would have been made but for the interruption plus the expenses that continue without income to cover them.

Both of these causes of loss are insurable, but they present special problems for the insurer, and insurance against them has by no means universal appeal to insureds. They may be covered by special forms of insurance.

(5) ***Pro-rata Liability.*** The standard policy includes a clause applying a general common-law principle to situations where more than one contract covers the property:

> This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not. [Lines 86–89.]

The phrase "whether collectible or not" exempts solvent insurers from acting as insurers of the credit of those that are unable to pay losses in full and, in effect, notifies the insured that he should see to it that any insurer with which he does business is financially sound. It also protects the insurer whose contract covers a loss from making good the amounts for which another would be liable had the insured not breached a condition. In a New Jersey case, the court said that payment by each insurer under the pro-rata clause is based

> upon the total of all policies issued with the knowledge and consent of the insured . . . and which on their faces covered the same property, the same insurable interest, and the same peril, even though a particular policy was or became void, voidable or suspended because of the insured's breach of condition.[6]

In this case the American Casualty Company's contract was for a face amount

[6] *Ekelchick v. American Casualty Co. of Reading, Pa.*, 152 A.2d 156 (1959).

of $5,000, the Firemen's Insurance Company's, $7,500, and the fire loss, $8,750. The property was vacant beyond a period of 60 days which was permitted under the former contract but not under the latter, and the fire occurred during the vacancy and after the 60 days. The Firemen's had no liability; the American's loss was $3,500 ($^{50}/_{125}$ of $8,750).

The fact that it is usual, in fire and allied forms of insurance, to have more than one, often many, contracts covering the same loss lends particular importance to this clause. However, the clause gives rise to little difficulty, except in those cases where the contracts are not *concurrent*, i.e., identical. In such cases, whether they are nonconcurrent in not covering exactly the same property but overlapping to some extent, or in being otherwise drawn in differing terms, their relative *contribution* to the payment of loss often presents intricate problems.

An example of the first type of nonconcurrency is found in the existence of overlapping *specific* and *blanket* contracts. An owner of a mercantile establishment might have contracts of varying amounts, each covering a specifically named stock, such as boots and shoes, millinery, drugs and cosmetics, and stationery. He might also have a contract covering his entire stock, as "general merchandise." The second type of nonconcurrency is exemplified by several contracts, some of which have a coinsurance clause, and some of which do not. And the two types may be found in a single group of contracts.

The problem is primarily one of determining how much each insurer pays. The insured is usually paid all that is due him, the insurers finally settling their contributions among themselves if there is a dispute. But annoyance and delay may be incurred by the insured, and he should plan his insurance to avoid such situations.[7]

Requirements in Case of Loss

The standard policy lists in detail the requirements that must be fulfilled by the insured in case of loss if he is to enforce his rights under the contract.[8] These requirements are valid, and failure to fulfill them may excuse the insurer from performance of its obligation, in the absence of any countervailing statute. They may be waived by the insurer, expressly or by implication. Acceptance without objection of a proof of loss giving less information than required

[7] The methods of making nonconcurrent *apportionments* and fixing contribution to loss are beyond the scope of this text. Most insurers abide by a 1963 revised version of several *Guiding Principles*. See W. D. Swift, "Development of Guiding Principles for First-Party Property Losses and Claims," available from the author at 85 John Street, New York City.

[8] The requirements in lines 90 to 113 must be fulfilled by the insured on his own initiative; those from 113 to 122, on demand of the insurer.

by the contract, consenting to an extension of the time for filing proof of loss, sending an adjuster who proceeds to negotiate a settlement, all may waive defenses based on previous failure of the insured to comply with the express conditions of the contract. But the only safe procedure for the insured is either to comply literally with the requirements or to obtain an express waiver from the insurer.

ENDORSEMENTS

The standard policy contains provisions applicable to all types of property but requires modification to suit it to particular types and to individual situations. This modification is accomplished by the addition of *endorsements*,[9] of which there are two general classes, *forms* and *clauses*.

Forms

The term "form" is often used as meaning any policy or endorsement drawn up in formal shape, but it also means technically the endorsement embodying appropriate modifying clauses and attached to the standard policy to adapt it to a broad class of property or a type of cover. The *dwelling and contents form*, used in insuring the class of property indicated by its title, contains clauses that are usually sufficient for that purpose. Similarly, one finds *school* forms, *hotel* forms, *theater* forms, *mercantile* forms, *manufacturing* forms, and many others. Among forms providing special types of cover are *business-interruption* forms, *rent* forms, *leasehold* forms, *builder's risk* forms, and *additional-living-expense* forms. Modification of the form itself or further modification of the standard contract to suit it to the individual risk is accomplished by items typed on the policy or by additional endorsements.[10]

Forms adapting the standard policy to a class of property are an essential part of every fire-insurance contract covering direct property losses. The most important additional information they provide concerns the property and the persons covered under the contract. For example, the building-and-contents form issued in connection with many business contracts tells the insured that the building item includes machinery used for the service of the building; ovens, kilns, and furnaces under certain conditions; awnings, screens, storm doors, and the like, if the property of the owner; and personal property such as janitors' supplies used in the service of the building. Contents include all

[9] Or *riders;* the two terms are synonymous.

[10] For examples and discussion of forms see the *Fire, Casualty and Surety Bulletins, Fire and Marine Section,* under Fire Forms.

personal property not excluded, the major exclusions being aircraft, automobiles, and property covered under the building item. The form states that in addition to covering the insured's own property, it covers property which the insured has on trust, commission, or consignment or for which he could be held liable if he were negligent. An important clause contained in this form is the coinsurance clause, the effect of which has been explained on pp. 144-149.

The dwelling-and-contents form also defines the dwelling item and the contents item. The insured is given the option at the time of the loss to include in his claim property belonging to other members of the family or servants. Because dwellings are a relatively low-hazard exposure, the insured is permitted to increase the hazard in certain ways (see p. 161) without breaching the contract. One interesting feature extends the contract to include losses of rental value during the period when the property is rendered untenantable because of a covered peril. Toward such losses the insured can recover as additional insurance 10 per cent of the amount of insurance on the dwelling but not to exceed one-twelfth of this amount for each month of untenantability. To illustrate, if a fire-insurance contract is written with $18,000 of protection applying to the building item, the insured can recover up to $18,000 for direct property losses to the building and, in addition, up to $1,800 for rental-value losses but no more than $150 per month of untenantability. Another important extension permits the insured to collect up to 10 per cent of the amount of insurance on the contents with respect to losses off the premises in the United States or Canada. Until the 1950's most families purchased a fire-insurance contract containing a dwelling-and-contents form. Today broader forms are available, particularly the homeowners forms, described in Chapter 19, and most middle- and upper-income groups have switched to these new forms. Similar, but somewhat less drastic, changes have occurred in the business-insurance field. Nevertheless, the study of these older forms will give the reader a better understanding of these more recent developments.

Clauses

Clauses endorsed on the policy, whether those contained in a form or those added separately, are permitted by the following clause in the standard contract:

> The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be

waived except such as by the terms of this policy is subject to change. [Lines 42 to 48.]

The clauses contained in the forms are usually applied as a matter of course in adding the appropriate form to the policy, though there may be some optional clauses included in the form. Other clauses are matters of negotiation or further customary adaptation. The principal purposes of the various and multitudinous clauses are:

1 Adding perils
2 Adding property
3 Adding persons
4 Adding types of loss
5 Adding locations
6 Extending the term
7 Granting special privileges with respect to contract conditions applying before a loss
8 Excluding perils, persons, property, types of losses, or locations
9 Imposing special conditions
10 Limiting the amount payable
11 Waiving requirements after loss

Examples of classes 1, 3, 7, 10, and 4 will be provided in the order named.

Extended-coverage Endorsement

The extended-coverage endorsement is so frequently made a part of the contract that it is included in certain forms, election to incorporate it in the contract being evidenced by a notation and premium charge on the face of the standard policy. It covers, typically, direct loss by windstorm, hail, explosion, riot, riot attending a strike, civil commotion, aircraft, vehicles, and smoke. Note that vandalism and malicious mischief are not included in this list. Another endorsement must be attached to cover this peril. The provisions of the standard policy and of other endorsements are made applicable to coverage of these perils by substituting the "peril involved or the loss caused thereby" for the word "fire" wherever necessary. The endorsement does not increase the *amount* of insurance; it merely adds covered perils. If the insurance against fire is in the amount of $5,000, that is the limit collectible under the contract, whether a loss is caused by one or more of the perils covered.

The *apportionment clause* of the endorsement should be carefully noted. It limits the liability of the insurer under the endorsement to the proportion of any loss that the amount of insurance under the policy to which the endorsement is attached bears to the total amount of *fire* insurance covering the

property. Suppose that one has three fire-insurance contracts covering a given piece of property, each in the amount of $3,000, with the extended-coverage endorsement applicable to one only. If a loss of $600 is caused by windstorm (or any other peril covered by the endorsement), the insured will collect only $200. The purpose of this provision is to penalize the insured who takes a small amount of insurance (relatively) under extended coverage, reasoning that losses caused by the added perils are likely to be small.[11] Further provisions of the apportionment clause have the same aim and deserve careful study.

Deductible clauses are a common feature of extended-coverage endorsements, providing that the insurer will be liable only for the loss in excess of a stated amount or percentage of the value of the property when caused by windstorm or hail.

Each added peril carries with it special provisions applicable only to it. Perhaps the special provision that has caused most difficulty is the exclusion applicable to windstorm and hail, of losses "caused directly or indirectly by . . . ice (other than hail), snowstorm, waves, tidal wave, high water or overflow, whether driven by wind or not." Insureds often do not realize that such losses are excluded and feel that they have been deceived or even go so far as to contest the insurer's refusal to pay losses due to the excluded causes.[12] Particularly unsatisfactory are the settlements of losses where either direct windstorm or one of the excluded causes, or both, may have been operative. For example, a cottage on the south shore of Long Island is razed and the remains scattered in the course of a hurricane. It may have been blown down by the direct force of wind, it may have withstood the wind and been destroyed by tidal wave, or it may have been partially damaged by wind, the job of destruction being completed by tidal wave. A 50 per cent compromise settlement leaves no one happy.

Since these endorsements vary considerably, attention should be given to the details of any actual endorsement.

Dwelling-and-Contents Broad Form

Families can also add perils to a fire-insurance contract by having a dwelling-and-contents broad form attached instead of the dwelling-and-contents form

[11] An optional-perils contract is available for the insured who does not want protection against all the extended-coverage perils or who wants different amounts of protection against some of these perils.

[12] See Abraham Kaplan and George I. Gross, "Report on the Lily-Tulip Cup Case."

described earlier. Under this form the perils clause is amended to include the extended-coverage perils (but more broadly defined than under the extended coverage endorsement[13]); vandalism and malicious mischief; sudden and accidental tearing asunder, cracking, burning, or bulging of a steam or hot-water heating system; falling objects; weight of ice, snow, or sleet; collapse of any part of a building; landslide; accidental discharge, leakage, or overflow of water or steam from within a plumbing, heating, or air-conditioning system or domestic appliance; breakage of glass; freezing of plumbing, heating, and air-conditioning systems and domestic appliances; and sudden and accidental injury to electrical appliances, devices, fixtures, and wiring from electrical currents artificially generated.

This broad form also differs from the traditional dwelling-and-contents form in that (1) the 10 per cent option covering rental-value losses covers all types of additional living expenses and there is not a one-twelfth limitation per month, (2) there is a 5 per cent extension applicable to trees, shrubs, and plants (limited to $250 per item), and (3) the insured can elect to have the property of his guests covered with respect to losses on the premises.

An interesting feature is replacement-cost insurance on the dwelling (not the contents) under certain conditions. The insurer promises that it will pay the actual cash value of the loss but, if the insured would benefit, it will pay instead that proportion of the full cost of repairing or replacing the damaged part of the dwelling that the amount of insurance bears to 80 per cent of the full replacement cost of the dwelling. To illustrate, assume that the insured's 10-year-old dwelling has an actual cash value of $20,000 and a full-replacement cost of $25,000. Further assume that the cost of repairing a burned portion of the dwelling is $10,000 but because of depreciation the actual cash value of the loss is $8,000. If the insurance amount is $15,000, the insurer will pay the higher of (1) $8,000 or (2) [$15,000/0.80 ($25,000) times $10,000] or $7,500. If the insurance amount is $20,000 or more, all losses will be covered at their full-repair or replacement cost up to the policy limits.

Dwelling-Building Special Form

The dwelling-building special form resembles the dwelling-and-contents broad form except that it covers only the dwelling and provides all-risks protection. Contents would be covered under the broad form or in some other way.

[13] For example, under the extended-coverage endorsement, smoke damage is limited to the sudden, unusual, and faulty operation of any heating or cooking unit. This limitation does not apply to smoke damage under the broad form under discussion.

Protection of Mortgagee

If loss is made payable to a mortgagee, lines 68 to 85 of the standard policy are applicable to him and his interest. But his rights and obligations are also regularly covered by a *standard mortgagee clause* endorsed on the policy, the provisions of which duplicate (to some extent) and amplify the standard policy provisions. Some of the provisions of the endorsement clearly relate back to an earlier standard policy and are probably unnecessary. In the following outline are given the rights and duties of the mortgagee under the combined provisions of the policy and of the usual endorsement.[14]

Rights of the Mortgagee.

1 Loss, if any, on building items, is payable to the mortgagee *as his interest may appear.*[15] The standard mortgagee clause may be used when personal property is mortgaged, but it is not usual. The mortgagee's interest is the amount of the mortgage debt, including both principal and any additional items. The loss is payable to the mortgagee even though the mortgagor has voluntarily restored the premises following a fire.

2 The insurance as to the interest of the mortgagee shall not be invalidated by any act or neglect of the mortgagor or owner, by any foreclosure or other proceedings or notice of sale relating to the property, by any change in title or ownership, nor by the "occupation" of premises for purposes more hazardous than permitted under the contract.

3 Cancellation of the contract *as to the mortgagee* or of the mortgagee clause may be effected only on 10 days' notice to the mortgagee.

Duties of the Mortgagee.[16]

1 If the mortgagor or owner fails to pay the premium, the mortgagee shall, *on demand,* do so.

2 The mortgagee shall notify the insurer of any change of ownership or occupancy or increase of hazard *that shall come to his knowledge* and

[14] Italics are not found in the contract; they are here introduced for emphasis. In connection with this discussion, the student should read lines 68 to 85 of the standard policy and the standard mortgagee clause, as contained in the building-and-contents form.

[15] The "loss payable" is that provided for under the terms of the insurance contract; e.g., if the contract contains a coinsurance clause, the mortgagee is subject to its provisions. But the mortgagor may not prejudice the rights of the mortgagee by agreeing to an improper adjustment or appraisal of the loss.

[16] These duties are regarded, with some exceptions, not as absolute obligations of the mortgagee, but only as conditions that must be fulfilled if he is to enforce his rights.

shall, *on demand*, pay the premium for the increased hazard, unless permitted by the contract.

3 If the insured fails to render proof of loss, the mortgagee shall, within 60 days *after notice thereof*, render proof of loss and be subject to the contract provisions relating to appraisal and time of payment and bringing suit.

4 If the insurer exercises its right (see below) to pay off the entire mortgage debt, it may require the mortgagee to assign to it the debt and the mortgage.

Example of Settlement. Assume that A, a mortgagor, obtains a fire-insurance contract in the amount of $5,000 from Company X on property which he has mortgaged to B as security for a loan of $4,000. The standard mortgagee clause naming B as mortgagee is attached, and losses under the contract are made payable to him. A loss of $3,000 occurs. The insurer admits its liability to A and pays in accordance with the exact terms of the combined provisions. Settlement would be made, and the relations of the three parties after the settlement would be, as follows:

X pays B	$3,000
A owes B	1,000

The rules behind this settlement may be stated as follows:

1 The insurance is for the financial benefit of the mortgagor.
   a He receives this benefit through reduction of the mortgage debt by the amount of the loss payment.
2 The loss is payable to the mortgagee alone, as his interest may appear.
3 If the loss paid is less than the amount of insurance, the remaining insurance protects the mortgagor, and the morgagee as his interest may appear.
4 The insurer is not subrogated to any rights under the mortgage.
5 The loss is payable by a joint draft only if both mortgagor and mortgagee accept such payment in satisfaction of their claims.[17]

In the usual case, the settlement is made by issuance of a draft, payable jointly to the mortgagor and mortgagee, but the mortgagee is entitled to demand payment to himself without joining the mortgagor. Endorsement of the draft by both parties acknowledges payment of the loss by the insurer. Disposition of the proceeds is by agreement between mortgagor and mort-

[17] Rather extensive consideration has been given to the protection of the mortgagee because, in the experience of one of the authors, it is a subject that gives rise to many misconceptions. See Prentiss B. Reed, "Adjustment of Property Losses," chap. 8.

gagee. In most cases the mortgagee is pleased to have the mortgagor use the proceeds to repair his property.

No Liability to Mortgagor. The insurer may be liable to the mortgagee but not to the mortgagor, where the mortgagor has failed to render proof of loss as required by the contract, or has otherwise violated provisions of the contract, the "insurance as to the interest of the mortgagee" in that case not being invalidated by the act or neglect of the mortgagor.

If the insurer *claims* that it is not liable, under the contract, to the mortgagor or owner, it is subrogated, to the extent of its payment of loss to the mortgagee, to the mortgagee's rights of recovery against the mortgagor, but without impairing the right of the mortgagee to collect any remaining portion of the mortgage debt. For example, if the insurer pays the mortgagee a loss of $3,000, but claims that it is not liable to the mortgagor, and the mortgage debt is $5,000, the mortgagee's right to collect $2,000 from the mortgagor has priority over the insurer's right to collect $3,000. If the total recovery from the mortgagor is only $4,000, the insurer receives only $2,000. The insurer has the option, if it claims that it was not liable to the mortgagor, of paying to the mortgagee the entire mortgage debt.

In either event, the mortgagor may contest the insurer's claim, and if he is successful, the result of the settlement will be the same as in the example of settlement given above.

Builder's Risk Insurance

From the time that material or equipment for the construction of a building is delivered to the site until the building is completed, the building owner, the prime contractor, and subcontractors are subject to possible loss, each in accordance with his interest. Buildings in course of construction and accumulations of materials and equipment are peculiarly exposed to the hazards covered by the extended-coverage, and vandalism and malicious-mischief, endorsements. The *builder's-risk* form is endorsed on the standard policy and normally covers the interests of owner and contractors in material on the premises, in contractor's equipment on the job, and in material and labor that have been put into the building. Each interest insured should be named in the contract.

The usual contract is written on the *completed-value* form, the amount of insurance being based on the completed value of the building. Contracts may also be written for a provisional amount (the values existing at the inception of the contract) to be adjusted by monthly reports of increases in value. Con-

tractors may insure their interests separately. Builder's-risk contracts are cancellable, with pro-rata adjustment of premium, on completion of the building.

Permissive Clauses

To forestall avoidance or suspension of the contract, it may be necessary to have special permission from the insurer to carry on certain activities or for the existence of certain conditions. The form, as a matter of course, contains certain *permissive* clauses that seem to be appropriate for the class of risks to which it applies. A typical dwelling-and-contents form grants permission

> (a) for such use of premises as is usual or incidental to the described occupancy; (b) for the described premises to be vacant or unoccupied without limit of time; and (c) to make alterations, additions and repairs and to complete structures in course of construction, and this policy (so far as it applies to building) covers all lumber and materials on the premises or adjacent thereto.

Sometimes a permit or extension is for a limited time and at an extra premium, as, for example, when permission is granted to carry on for a limited time a hazardous process like the operation of a motion-picture machine. The insurer may be willing to extend the coverage if certain conditions are met, and the permit may carry a warranty that they will be met.

The 1943 policy is suspended "while the hazard is increased by any means within the control or knowledge of the insured." The question whether there is such an increase is a question of fact, not of policy interpretation. In a trial in court of a disputed claim this question would be left to the jury. With these permits in the attached form or endorsement, so much of the increase of hazard as they cover does not suspend the insurance.

Coinsurance

Coinsurance has already been discussed.[18] In fire insurance the principle of coinsurance is required by insurer organizations to be applied rather generally in the insurance of exposures other than private dwellings or farm buildings. Usually at least two premium rates are quoted, one for contracts without coinsurance and another for contracts with coinsurance. The rules vary considerably from locality to locality.

[18] See pp. 144–149.

Distribution Clause

The *distribution clause* or *pro-rata distribution clause* is worded, with slight variations, as follows:

> It is a condition of this contract that the amount insured hereunder shall attach in or on each building, shed and other structure and/or place in that proportion of the amount hereby insured that the value of the property covered by this policy in or on each said building, shed and other structure and/or place shall bear to the value of all the property described herein.

The effect of this clause is to convert a contract for a single stated amount of insurance, covering several items of property, into contracts for pro-rata amounts on the several items. Its operation may be illustrated by the case of a contract in the amount of $25,000 covering four buildings. The clause would result in the following amounts of insurance on the several buildings:

	Value	Proportion	Insurance
Building 1	$20,000	20/50	$10,000
Building 2	10,000	10/50	5,000
Building 3	5,000	5/50	2,500
Building 4	15,000	15/50	7,500
Total	$50,000	50/50	$25,000

The pro-rata distribution clause has no effect on the insured's recovery unless the loss is a large one. Usually a blanket policy covering contents at several locations contains either a 90 per cent coinsurance clause, an 80 per cent coinsurance clause, or an 80 per cent coinsurance clause and a pro-rata distribution clause. In the last instance, the insurance is first prorated and then the coinsurance principle is applied. For example, the insurance would first be prorated as in the above example. If there were a loss at Building 1, the insurer would pay $10,000/0.80 ($20,000) of the loss subject to a maximum payment of $10,000.

Deductibles

During recent years increasing interest in contracts providing for deductible amounts applicable to large risks has developed, both among insurers and insureds. The *deductible endorsement* is written to provide for deduction of

amounts ranging from $5,000 to $250,000 from each loss covered by the contract, the insurer being liable for the excess over the amount of the deductible up to its *limit of liability*. The deductible is applied separately to each occurrence, location, or item, as may be agreed, and may vary in amount between fire, extended coverage, and vandalism and malicious mischief insurance.

Additional insurance may not be carried except by permission of the insurer, and the deductible itself may not be specifically insured. The purpose of the latter provision is to maintain the interest of the insured in preventing loss.

Excess of Loss Insurance. While the approach to writing excess of loss insurance is different from that outlined under "deductibles," the purpose is much the same, to permit an insured to carry his own risk to the extent that he feels it to be practicable, economizing on premium outlay and getting the benefit of any reduction in losses that he may effect through prevention, while being protected against serious losses.

The contract, less standardized than the deductible contract, insures against the amount of a loss in excess of a stated amount. For example, the contract may cover losses in excess of $100,000, the insurer being liable, if the loss amounts to $250,000, for $150,000.

Business Interruption Insurance

Any peril that can cause loss to the physical property of a business may have the further effect of causing partial or complete interruption of business operations. Such interruption may result in loss of net profits that would otherwise have been earned and in incurring necessarily continuing expenses that are not covered by continuing income. There is no necessary relationship between the extent of the physical loss and the amount of the business-interruption loss. A slight physical damage cutting off power might result in total suspension of business and a large business-interruption loss; a considerable physical loss, such as that of an entire manufacturing unit shut down during a period of poor business is no business-interruption loss at all.

The purpose of business interruption insurance is to continue coverage where the standard policy leaves off (since the policy provides for payment of loss "without compensation for loss resulting from interruption of business or manufacture"). Such insurance is afforded by *business-interruption forms* endorsed on the standard policy.

The most recently developed contract is written on the *gross-earnings form*, which states the liability of the insurer as follows:

In the event of such damage or destruction this Company shall be liable for the ACTUAL LOSS SUSTAINED by the Insured resulting directly from such interruption of business, but not exceeding the reduction in Gross Earnings less charges and expenses which do not necessarily continue during the interruption of business, for only such length of time as would be required with the exercise of due diligence and dispatch to rebuild, repair or replace such part of the property herein described as has been damaged or destroyed, commencing with the date of such damage or destruction and not limited by the date of expiration of this policy. Due consideration shall be given to the continuation of normal charges and expenses, including payroll expense, to the extent necessary to resume operations of the Insured with the same quality of service which existed immediately preceding the loss.

Gross earnings are defined, for manufacturing risks, as:

(a) Total net sales value of production,
(b) Total net sales of merchandise, and
(c) Other earnings derived from operations of the business, less the cost of:
(d) Raw Stock from which such production is derived,
(e) Material and supplies consumed directly in the conversion of raw stock into finished stock or in supplying the service(s) sold by the Insured,
(f) Merchandise sold, including packaging materials therefor, and
(g) Service(s) purchased from outsiders (not employees of the Insured) for resale which do not continue under contract.

Gross earnings are defined, for mercantile or nonmanufacturing risks, as:

(a) Total net sales, and
(b) Other earnings derived from operations of the business, less the cost of:
(c) Merchandise sold, including packaging materials therefor,
(d) Materials and supplies consumed directly in supplying the service(s) sold by the Insured, and
(e) Service(s) purchased from outsiders (not employees of the Insured) for resale which do not continue under contract.

In both cases it is provided that:

No other costs shall be deducted in determining Gross Earnings.

In determining Gross Earnings due consideration shall be given to the experience of the business before the date of damage or destruction and the probable experience thereafter had no loss occurred.

It is a condition of the contract covering mercantile or nonmanufacturing risks that

> if the Insured could reduce the loss resulting from the interruption of business,
>
> (a) by complete or partial resumption of operation of the property herein described, whether damaged or not, or
> (b) by making use of other property at the location(s) described herein or elsewhere.
>
> such reduction shall be taken into account in arriving at the amount of loss hereunder.

For manufacturing risks is added to (a) and (b) the following:

> (c) by making use of stock (raw, in process or finished) at the location(s) described herein or elsewhere,

Expenses to reduce loss are covered by the following provision in the mercantile or nonmanufacturing contract:

> This policy also covers such expenses as are necessarily incurred for the purpose of reducing loss under this policy (except expense incurred to extinguish a fire), but in no event shall the aggregate of such expenses exceed the amount by which the loss under this policy is thereby reduced. Such expenses shall not be subject to the application of the Contribution Clause.

The manufacturing contract adds:

> such expenses, in excess of normal, as would necessarily be incurred in replacing any finished stock used by the Insured to reduce loss. . . .

The contract in either form includes a coinsurance (contribution) clause providing for 50, 60, 70, or 80 per cent coinsurance, the amount to which the percentage is applied being

> the Gross Earnings that would have been earned (had no loss occurred) during the 12 months immediately following the date of damage to or destruction of the described property.

Note that there is no deduction for noncontinuing expenses in determining the base to which the coinsurance percentage is applied.

The contract in either form is extended in the following way:

> to include the actual loss as covered hereunder during the period of time, not exceeding 2 consecutive weeks, when, as a direct result of the peril(s) insured against, access to the premises described is prohibited by order of civil authority.

Ordinary Payroll Exclusion. Ordinary payroll, defined as:

> The entire payroll expense for all employees of the insured, except officers, executives, department managers, employees under contract and other important employees

may be excluded from coverage, either entirely or for not exceeding 90 (120, 150, or 180) "consecutive calendar days immediately following the date of damage to or destruction of the described property." If such payroll is excluded, 80 or 90 per cent coinsurance is required, the percentage being applicable to gross earnings as defined in the contract, less the same percentage of the ordinary payroll expense excluded from coverage. Unless ordinary payroll is a large portion of the gross earnings and is likely to be discontinued even during a short interruption, the gross-earnings form without any exclusion is more attractive because of the lower coinsurance percentages possible and the greater flexibility it permits, following a loss, with respect to whether the payroll should be continued.

Contingent Business Interruption Insurance. The operation of a business may be interrupted by "damage to or destruction of" the properties of its suppliers, or a supplier's operations may be interrupted by loss to the properties of its customers that prevents acceptance of its products. Loss due to such interruptions may be covered by *contingent business interruption insurance* "for contributing properties" or "for recipient properties," the receiver of supplies being the insured in the first case and the supplier in the second.

Extension of Period of Indemnity. Until recently the coverage of business interruption insurance ended with the physical restoration of the damaged or destroyed property, as explained above. But loss from interruption of business may well continue; customers may have been lost, adjustments may have to be made to bring the business back to its condition before the interruption.

A new *endorsement extending the period of indemnity* may now be added to the basic business-interruption form covering the

> Loss Sustained . . . resulting directly from the interruption of business, as covered by this policy, for such additional length of time as would be

> required . . . to restore the Insured's business to the condition that would have existed had no loss occurred. . . .

The endorsement excludes from coverage any increase of loss due to "the suspension, lapse, or cancellation of any lease or license," "interference at the described premises by strikers or other persons," and "any other consequential loss or remote loss."

Extra-expense Insurance

Certain businesses of a service nature are especially concerned to maintain continuous operation in order to avoid loss of customers and consequent reduction of volume of business *after* the period of suspension of operations. Among such businesses are banks, newspaper and magazine publishers, laundries, and suppliers of perishable foods. Public utilities providing an essential service fall in the same category. All businesses may have a maximum period beyond which they do not want to be shut down.

Extra-expense insurance meets their needs. It affords insurance against the *extra* expense of continuing operation necessitated by damage to their physical property. Examples of such extra expense are the rental of substitute premises and moving expenses of a bank, the payment of higher costs of printing and maintaining supervision by a newspaper publisher, and the higher cost to a dairy of buying and transporting milk.

Additional Living Expense. Akin to the businessman's extra expense for continuing operations is additional living expense, defined as

> the necessary increase in living expense incurred by the Insured to continue as nearly as practicable the normal standard of living of the Insured's household for the applicable period described in (a) or (b), below:
>
> (a) The time required, with the exercise of due diligence and dispatch, to repair or replace such damaged or destroyed property.
>
> (b) The time required for the Insured's household to become settled in permanent quarters.

amplified and limited as follows:

> The periods described in (a) and (b) above shall not be limited by the date of expiration of this policy.
>
> This Company shall also be liable for the necessary increase in living

expense, during the period of time, not exceeding two weeks, while access to the described premises is prohibited by order of civil authority, but only when such order is given as a direct result of damage to neighboring premises by a peril insured against.

This Company shall not be liable for additional living expense due to the cancellation of any lease, or any written or oral agreement.

Such expense may be covered by a special clause or as part of the form, endorsed on the standard policy. Typical expense of the sort covered is the excess expense of living in a hotel, including extra food, transportation, and laundry expense, while one's residence is being repaired.

Rent and Rental-value Insurance

A casualty may render rented or rentable premises untenantable. If the premises are rented, the landlord may be deprived of rents that he would have received had they remained tenantable. A tenant whose rent continues during a period of untenantability is deprived of the rental value that he would otherwise enjoy. A landlord is deprived of rental value when the premises operated by him are untenantable, whether or not the premises are rented.

These various losses may be covered; the first by rent insurance, the others by rental-value insurance. Such insurance covers the *net loss*, i.e., the loss after deducting from rents or rental value lost the "charges and expenses which do not necessarily continue during the period of untenantability."

Leasehold Insurance

A lessee whose premises have become untenantable may suffer loss under any of the following conditions:

1 If the rental value of the premises is greater than the rent paid by the lessee
2 If the lessee is subletting the premises, or any part of them, at a profit
3 If the lessee has paid a bonus for the lease
4 If the lessee has installed at his own expense improvements that have become the property of the landlord
5 If the lessee is in possession under a lease that does not provide for cancellation or abatement of rent in case of fire

Any loss in this category may be covered by leasehold insurance. The amount of loss often depends on the fire clause in the lease or on a statute, either of which may determine whether or under what conditions a lease is canceled by a fire making the premises untenantable.

Profits and Commissions Insurance

> In the insurance scheme, *profits* may be defined as the difference between the replacement cost of merchandise on hand at time of loss and its selling price; *commissions*, as the amount that the person who is to sell merchandise for another would earn by selling it. . . . The intent of profits insurance, when written in connection with insurance on the merchandise itself, is to make it possible for the insured to collect in case of total loss the same amount of money that he would have received had he sold the merchandise in sound condition, less any expense he could avoid or discontinue because of its destruction.[19]

There is a tendency to insure finished goods in the hands of a manufacturer under a *market-value* clause which provides for payment of loss on the basis of selling price, less discounts, and less any expense eliminated by the loss, thereby eliminating any need for profits insurance.

Replacement Insurance

The actual cash value of a loss under the standard contract is the depreciated value of the property involved. But the insured may find it necessary to expend considerably more than the amount in replacing or repairing his property. Subject to restrictions, he may now, in many jurisdictions, buy *depreciation* or *replacement cost* insurance on buildings and to a limited extent on equipment, the effect of which is to eliminate the deduction for depreciation which is normally a part of the calculation of actual cash value.

Payment by the insurer of the amount in excess of normal cash value is always conditioned on actual repair or replacement, with varying conditions as to the time within which repair or replacement must be effected. Forms may require *rebuilding* on the same site and with identical construction, but less restrictive forms are written.

This insurance is subject to a high degree of moral hazard and is written with care to accept only risks superior in respect of that quality.

PERPETUAL CONTRACTS

A few insurers write perpetual insurance. This business is of little importance compared with the fire-insurance business as a whole; it is chiefly of interest as that written by the oldest fire insurer[20] in the United States and as an illustration of the possibility of doing business in an unconventional fashion.

[19] Reed, *op. cit.*, p. 457.

[20] The Philadelphia Contributionship for the Insurance of Houses from Loss by Fire, founded in 1752 by Benjamin Franklin and others.

The contract briefly here described is that used by the Philadelphia Contributionship.

The contract form is the Standard Perpetual Policy for Pennsylvania modified (as permitted by its terms) by the Deed of Settlement of the Contributionship.

In consideration of a deposit (currently 25 times an assumed annual premium) the contract continues in force without time limit. Payment of a partial loss does not reduce the insurance nor require additional deposit. Payment of a total loss terminates the insurance, and the deposit is refunded. The contract may be canceled by the insured. If his deposit has been held less than 3 years, 90 per cent is refunded; if more than 3 but less than 5 years, 95 per cent; if more than 5 years, 100 per cent.

The extended-coverage endorsement may be added for an additional deposit of 1.5 per cent of the amount of the contract.

Insureds have, since 1895, received annual dividends of 10 per cent of deposits, for fire insurance only, after the deposits have been held 10 years or more.

FIRE LIABILITY INSURANCE

Liability to others for loss caused by fire may arise out of contract or negligence. One may assume by contract responsibility for the safety of property in one's care—responsibility that may be complete or partial. And one is always responsible for the results of one's negligent acts. Full discussion of the loss that may result from these situations, and insurance against it, is impractical here. The subject is noted for the benefit of those who do not realize the existence of the hazard.

QUESTIONS

1 A furnace becomes overheated and causes loss by spoilage of sugar exposed to the heat. Would this loss be covered by the fire-insurance contract?

2 An insured under the fire-insurance contract sustains a loss by $5,000 by damage to his building, $5,000 in addition because he is required by law to use better materials for repairs than those which had been previously used in constructing the building, and $10,000 due to suspension of production, all caused by fire. The amount of his insurance is $40,000. How much may he collect?

3 Personal property is insured under the fire-insurance contract and is described as located on the insured's premises. While a suit is at the

cleaner's it is destroyed by fire. May the insured collect the amount of the loss from the insurer?

4 Jones insures his house, described as used as a dwelling, under the fire-insurance contract. He installs a dry-cleaning business in the basement without securing permission from the insurer. A fire in the attic causes loss confined to that part of the house. May Jones collect? If he discontinues his dry-cleaning business, removes all of the equipment and supplies, and the loss occurs thereafter, may he collect?

5 Jones gives Smith a mortgage on his house to secure a debt of $10,000. Jones insures the house against fire in the amount of $15,000, the standard mortgage clause naming Smith as mortgagee being attached. The contract is in full force as to both Jones and Smith when a fire occurs causing a loss of $6,000. Assuming that each party enforces his rights fully, what payments would be made and to whom? What would be the financial relations of the parties (including the insurer) after the settlement?

6 Brown insures his house against fire in the amount of $20,000; $10,000 in insurer A, $5,000 in insurer B, and $5,000 in insurer C. Believing that the various perils covered by the extended-coverage endorsement are likely to cause only small losses, he has that endorsement added only to the contract with C. The house is damaged to the extent of $2,000 by windstorm. How much may Brown collect from each insurer?

7 Contrast the purposes of business interruption insurance and extra-expense insurance.

8 A mercantile firm with stable business experience has annual net sales of $2,000,000. The cost of goods sold is $1,000,000, the payroll $500,000, and other expenses $400,000. Half of the payroll is ordinary payroll. How much insurance would the business have to purchase to avoid a coinsurance penalty under a gross-earnings business-interruption form with a 50 per cent coinsurance clause? Under such a form with an ordinary payroll-exclusion endorsement and an 80 per cent coinsurance clause?

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MARINE-INSURANCE CONTRACTS

Marine insurance is the oldest branch of the insurance business. No record of an insurance business in the modern form among the ancients has come down to us, though bottomry (ship) and respondentia (cargo) loans served in a limited way to perform the same economic function. These loans were made on the security of marine ventures and were repayable with maritime (high) interest if the voyage was successfully completed, but were canceled if it failed. If the lender negotiated a large number of such loans, he had a more or less regular ratio of loss, and a part of his interest charge was in the nature of an insurance premium to pay losses.

The precise time and place of origin of modern marine insurance are unknown, but it is generally agreed that the time was prior to A.D. 1400 and among the Lombard and Venetian traders in the Mediterranean. It is certain that insurance was brought to London by the Lombard merchants, and the name "policy" (from *polizza*—a written and folded document) given the written insurance contract is evidence of its Italian origin. The early business was not done by corporations as is usual now, but by individual insurers. The proposal was presented at a common meeting place of traders; those willing to accept part of the risk attached their signature at the bottom and indicated the amount they assumed, with notations of any further limitations that might be agreed to. From this practice comes the term *underwriter,* which designates one who is skilled in passing upon the desirability of accepting particular risks and in fixing terms of acceptance.

At a somewhat later time the coffeehouse of one Edward Lloyd was a congregating place for those interested in seafaring ventures, and a center for marine news. It became headquarters for traders who were disposed to become underwriters of marine risks. Gradually, as the volume of such transactions increased, a few, and later an increasing number, gave up their other trading to specialize in underwriting. In 1771 an organization of the underwriters at Lloyd's, London, was formed, which persists to the present time. The form of policy for covering the marine risk was gradually standardized,

until the underwriters adopted and printed a standard Lloyd's form of contract in 1779. Through the decision of innumerable cases since that time, every phrase and word of this old contract has received the attention of the courts, with the result that, at least among English-speaking countries, the old contract is the core of all marine-insurance policies; this despite its archaic language, which to a modern is almost meaningless jargon. The modern American policy does not rigidly follow the old form, but its outstanding features are the same.

MARINE-INSURANCE LAW

The principal reason for retaining the form and language of the original Lloyd's contract is the body of interpretive law that has grown up around it. Lord Mansfield, who became Lord Chief Justice of England in 1746, interpreted the contract in the light of legal precedent and commercial usage and laid the solid foundation of what is now the accepted marine-insurance law of Great Britain and the United States. By the Marine Insurance Acts, 1906 and 1909, the British law was codified, and the Lloyd's policy was established as the official, but not mandatory, form of contract. The 1906 act provides that the policy "may be" in that form, and the rules for the construction of "a policy in the above or other like form" are set forth in the first schedule of the act.

There are three outstanding characteristics of the application of law to the marine-insurance contract. First, it is a contract *uberrimae fidei,* of utmost good faith. While this is a characteristic of insurance contracts in general, it is of special importance in marine insurance, where the insurer must rely on the information furnished by the insured and on his proper conduct to a much higher degree than in other forms of insurance. The insurer is likewise more dependent on the cooperation of the insured than is the case elsewhere.

Second, the contract is more strictly interpreted than are other insurance contracts. The parties, since insureds are generally well-informed businessmen usually represented by specialized brokers, are more nearly equal in respect of negotiating and observing the contract. And the special importance of the requirement of utmost good faith indicates the need of such interpretation.

Third, much is read into the contract by implication. The tendency is to regard the policy as containing all the terms of the contract.

MARINE INTERESTS

There are three principal interests involved in the usual marine venture: *hull, cargo,* and *freight.* The hull interest is evidenced by the ship and its equipment; the cargo interest, by merchandise carried; and the freight interest, by

the earnings of the ship. Since fortuitous events may cause loss to any of these interests, they are insurable interests.

The relations of persons or organizations to these basic interests are varied. A ship may carry only cargo belonging to the owner of the ship who himself operates it. He would have an insurable interest in each of the three categories. Or a ship may be chartered by the owner, who has mortgaged her, to an operator, who carries cargo belonging to still other parties, who finance their shipments through banks. Each of these persons or organizations has an insurable interest, as would any other who could show a possibility of fortuitous loss.

TYPES OF CONTRACT

While the basic provisions of the contract are much the same for all types, there are sufficient differences to recognize four outstanding types: *hull, cargo, freight,* and *liability.*

Hull Contracts

Insurance of the vessel and its equipment is effected under various sorts of hull form. Some of the factors that call for considerable modification of the basic form are the type of vessel, whether sailing, auxiliary, yacht, or motorboat; the trade in which the vessel is engaged, such as Great Lakes or river traffic; the status of the vessel, whether operating, laid up in port, or in process of construction. The last situation mentioned has given rise to a specialized contract, the *builder's-risk* form.

Cargo Contracts

Cargo contracts may be written as *special* policies, covering a single shipment, or as *open* policies, covering future shipments as defined by the contract. It is in the negotiation and writing of open policies that the marine-insurance business exemplifies best its talent for suiting the contract to the needs of the insured. An importing-and-exporting house that deals in a wide range of commodities from and to several countries may arrange a contract under which the insurer (usually one insurer) will agree to cover shipments of specified commodities by conveyances and within geographical limits also specified, actual shipments to be reported as made and premium on them to be paid periodically (usually monthly).[1] The insured is authorized to issue negotiable

[1] The liability of the insurer is limited to specified amounts by any one vessel, at any one place or time, or in any one disaster or accident.

special policies evidencing insurance of the shipments, and available by endorsement as protection to the financing bank and/or the consignee. The certificate, which referred to the original open policy but did not include many of its terms, has fallen into disuse. Special policies embody all the terms of the open policy under which they are issued, referring to it only by number, and are now generally used.

Freight Contracts

Freight is the money agreed to be paid for the carriage of property (in maritime language, *not* the property carried) or, if a vessel is chartered, the money to be paid for the use of the vessel. Loss of freight money to the operator or owner of the vessel may result from inability to perform the service contracted for, which in turn may result from a casualty insured against. Hence the insurable interest in freight. The full amount of earnings lost by reason of a covered casualty is payable by the insurer, no account being taken of expenses made unnecessary by the same cause.

Liability Contracts

The owner or charterer of a vessel may become liable by law or by contract for damages or compensation on account of injuries to persons, cargo, or other property, for unusual expenses to comply with governmental regulations, or for penalties incurred by violation of law. His liability to other vessels and their cargoes for damages on account of collision is usually covered by a clause in the hull policy. Protection against other liabilities is covered by *protection-and-indemnity insurance* (usually spoken of as P-and-I insurance) under a P-and-I policy contract or by extension of the hull contract.[2]

CONTRACT PROVISIONS

Coverage

The Insured. The insurer and insured are named in the usual way, but other interested parties are included by the phrase "for account of whom it may concern" in American contracts and by similar phrases in British contracts. This phrase does not mean that all possible interested parties are covered but

[2] Liability for failure to meet engagements to furnish transportation is excepted; this liability, if due to a fortuitous cause, may be covered under a freight contract.

only those persons or organizations that the named insured intended to include in making the contract and who authorized his action in making it or who may ratify such action prior to loss. More specifically the contract may include additional interests by making the contract "for account of" named additional insureds.

Perils Covered. A current cargo policy enumerates the perils insured against as follows:

> Touching the adventures and perils which the said . . . . . Insurance Company is contented to bear, and takes upon itself in this voyage, they are of the seas, men-of-war, fires, enemies, pirates, rovers, thieves, jettisons, letters of mart and countermart, reprisals, takings at sea, arrests, restraints and detainments of all kings, princes, or people, of what nation, condition or quality soever, barratry of the master and mariners, and all other perils, losses and misfortunes that have or shall come to the hurt, detriment or damage of the said goods and merchandise, or any part thereof.

The wording of this clause stems from the Lloyd's form. If marine insurance were of recent origin, the more or less obsolete terms would not have been employed, but the language has been so thoroughly interpreted over the long years of its use that revised wording might be less clear.

This statement of perils makes the contract practically an all-risks contract, but other clauses contain exceptions and exclusions, and the courts apply to "all other perils, losses and misfortunes" the rule of reason. Losses, to be covered, must be *ejusdem generis*, of the same kind as those specifically mentioned. Loss from ordinary wear and tear or from *inherent vice* is not covered.

Perhaps the most important question to arise under the *ejusdem generis* doctrine was whether bursting of boilers and accidents to ships' machinery were "of the same kind" and therefore covered under the perils clause. In the leading case of a machinery loss on the steamer *Inchmaree*, the House of Lords decided that they were not. This decision led to the general adoption of the *Inchmaree clause*, which, in a standard American hull form, reads as follows:

> This insurance also specially to cover (subject to the Average Warranty) loss of or damage to the subject matter insured directly caused by the following:
>
> Accidents in loading, discharging or handling cargo, or in bunkering;

> Accidents in going on or off, or while on drydocks, graving docks, ways, gridirons or pontoons;
> Explosions on shipboard or elsewhere;
> Breakdown of motor generators or other electrical machinery and electrical connections thereto, bursting of boilers, breakage of shafts, or any latent defect in the machinery or hull, (excluding the cost and expense of replacing or repairing the defective part);
> Breakdown of or accidents to nuclear installations or reactors not on board the insured Vessel;
> Contact with aircraft, rockets or similar missiles, or with any land conveyance;
> Negligence of Charterers and/or Repairers, provided such Charterers and/or Repairers are not Assured(s) hereunder;
>
> Negligence of Master, Mariners, Engineers or Pilots;
>
> provided such loss or damage has not resulted from want of due diligence by the Assured, the Owners or Managers of the Vessel, or any of them. Masters, Mates, Engineers, Pilots or Crew not to be considered as part owners within the meaning of this clause should they hold shares in the Vessel.

In the cargo form, the coverage is similarly extended to cargo losses:

> This insurance is also specially to cover any loss of or damage to the interest insured hereunder, through the bursting of boilers, breakage of shafts or through any latent defect in the machinery, hull or appurtenances, or from faults or errors in the navigation and/or management of the vessel by the master, mariners, mates, engineers or pilots.

Property Covered. The printed cargo form covers "all kinds of lawful goods and merchandise," but the actual coverage is not so broad. Except in open policies, it is customary to write a description of the specific property insured immediately before this phrase. In this description it is desirable to identify the goods by specific marks, as, for example, "100 cases canned asparagus, marked Livingston, Brown & Co. XXX."

The policy form identifies the goods as "laden or to be laden." Commercial necessity dictates that the goods must never be left unprotected. Hence the policy should be arranged before the loading so that it may take effect as to each piece of property as soon as it comes within its scope. This language describes the goods to be covered, viz., those intended to be carried on the ship named in the policy.

The policy provides space for naming the vessel and its master, though it

provides also for the possibility of the vessel sailing under a different name or a different master. The fitness of the vessel for the contemplated voyage is a most important consideration for the underwriter in determining the acceptability of the risk. It is therefore of the utmost importance that the vessel be correctly identified, and if this is accomplished, it is immaterial if the name is changed. This provision will not save one who misrepresents the vessel involved, but if the name is changed and both parties correctly understand the identity of the vessel, the contract holds. A consideration to the underwriter scarcely second to the fitness of the vessel is the skill of the master, and it was formerly important that the exact facts as to who was master be communicated. With the growth of shipping, it has not been possible always to follow this requirement. Usually this blank is not filled in, and some insurers omit from their policies any reference to the master.

Under a hull contract, not only the bare hull of the ship, but also its machinery and entire equipment are covered.

Sue-and-labor Clause. Immediately after the perils clause appears the following:

> And in case of any loss or misfortune, it shall be lawful and necessary to and for the assured, . . . factors, servants and assigns, to sue, labor and travel for, in and about the defense, safeguard and recovery of the said goods and merchandises, or any part thereof, without prejudice to this insurance; nor shall the act of the insured or insurers, in recovering, saving and preserving the property insured, in case of disaster, be considered a waiver or an acceptance of an abandonment; to the charges whereof, the said Insurance Company will contribute according to the rate and quantity of the sum herein insured.

This agreement, strictly speaking, is not one of insurance; it is an addition to the contract of insurance and collateral to it, and limited to activities on behalf of the insurer. The insured or his representatives are at the scene of the casualty and best situated to direct preventive activity. The loss that the insured seeks to prevent or reduce must be one that the insurer would be obligated to pay. Even if the insured's efforts are wholly or partially unsuccessful, he is entitled to reimbursement for expenses under this clause, to the extent that he has acted in the insurer's interest.

Term. The term, or period during which a marine-insurance contract is in force, varies with its purpose. A contract may be written to cover a ship or cargo for a single voyage, an open-cargo contract may continue in force until canceled in accordance with its provisions, or a contract may cover for a

specified period of time. These and other variations may be written into the contract at the option of the parties—there is no statutory requirement in the United States.

The hull contract usually covers a fixed term rather than a voyage and therefore provides for cancellation by mutual consent and for refund of premium at a rate specified. It also provides for refund for periods of idleness when the risk is much reduced. It contains a provision that, if the vessel is at sea when the term of the contract expires, the contract is extended at the same premium rate pro rata until she reaches her destination.

Coverage under a builder's-risk form begins with the laying of the keel and continues for a fixed term unless the vessel is delivered before that date, when the contract is terminated and a refund made. It may be extended to the time of completion and delivery of the vessel if the original term ends earlier.

Assignment

The marine-insurance contract is assignable without the consent of the insurer, unless such assignment is expressly prohibited in the contract. Hull contracts, but not cargo contracts, usually expressly require the consent of the insurer.

Consideration

Both United States and British contracts state that the premium has been paid, but the statement is not a receipt for the premium. If it has not been paid, the insured still owes it to the insurer.

Types of Loss

Marine losses are classified under heads peculiar to maritime affairs and to marine insurance. While all fortuitous losses might be covered by a marine-insurance contract, they are not always so covered. In the arranging of contract terms and premium rates, insurer and insured consider the effect of including and excluding various types or amounts of loss and attempt to arrive at an agreement that will be profitable for the one and economical for the other. Some of these variations will be explained in later sections. Here are considered the losses that may be covered in whole or in part.

Actual Total Loss. Actual total loss of insured property means its disappearance, destruction, or damage beyond the possibility of repair or recovery. A ship or cargo at the bottom of the sea at a point from which it could not be

raised, entirely consumed by fire, or irretrievably broken up and scattered by an explosion are examples of actual total loss.

Constructive Total Loss. There is a constructive total loss when the property is so damaged or so placed that repair or recovery will cost as much as, or more than, the repaired or recovered value. Salvage is possible but not practical. This type of loss is the financial equivalent of actual total loss and, when proved, calls for the same indemnification. The rule stated is that of British law. The original rule in the United States was that there is a constructive total loss if the cost of repair or recovery exceeds 50 per cent of the repaired or recovered value. However, it is usual to make the British rule a part of hull contracts. The 50 per cent rule applies to cargo losses when no substantial part of the goods arrives in specie at destination, but a special clause usually provides that no recovery for a constructive total loss shall be had unless preserving the property from actual total loss would require an expenditure equal to or exceeding its saved value.

Abandonment. In order to collect indemnity for either sort of total loss, the insured tenders abandonment of his property to the insurer. If the tender of abandonment is justified by the facts the insurer becomes responsible for the indemnity provided by the insurance contract for total loss, but it is not obligated to accept abandonment whenever tendered.

Particular Average. The term *average*, in marine language, means *loss;* it has no connection with average in the sense of a mean. Particular average is a partial loss falling entirely on the interest involved. For example, if cargo should be accidentally ignited and be partially damaged, the loss would be a particular average. Similarly, if wave action damaged the superstructure of a ship, the loss would be a particular average.

The loss of a complete unit of a cargo shipment made up of several units is termed *total loss of a part,* rather than particular average.

General Average. According to the York-Antwerp Rules 1950:

> There is a general average act when, and only when, any extraordinary sacrifice or expenditure is intentionally and reasonably made or incurred for the common safety for the purpose of preserving from peril the property involved in a common maritime adventure.

And Winter says[3] that:

> A general-average loss is one which is the result of a sacrifice voluntarily made, under fortuitous circumstances, of a portion of either ship or cargo or the voluntary incurrence of expense for the sole purpose of preserving the common interest from an impending danger. When a vessel becomes involved in a peril, and when, in order to save the common venture from that peril or to extricate it from its ultimate results, sacrifices are made or expenses are incurred by the master acting for the benefit of all concerned, these sacrifices and expenses must be borne by all the interests involved, whether ship, freight, or cargo. The values saved, as well as the values sacrificed, must contribute to this general average so that all the interests will be placed in the same relative position.

The principal of general average antedated, and is entirely independent of, marine insurance. Its purpose is, and always was, to regularize the cooperation of the various interests in a marine venture in substituting partial losses for a total loss of the entire venture. The initial loss of cargo thrown overboard to lighten ship, of spars cut away to restore stability, of ship or cargo damaged by efforts to extinguish a threatening fire is a general-average *sacrifice*. The eventual loss to each interest is a general-average *contribution*. *Charges* and *expenses* for the common good are treated in the same way as sacrifices.

The York-Antwerp Rules, cited above, are the end result of several international conferences of maritime lawyers and other interested persons and serve as a guide to what may be considered a general-average sacrifice or expense and to how it shall be distributed among the interests. The work of determining the amounts involved and assessing them upon the interests is carried out by general-average *adjusters* and is called a general-average adjustment.

> The amount of detail involved in these cases depends in large measure on the number of interests involved and the number and nature of sacrifices and expenses incurred. The preparation of a general-average adjustment in the case of a vessel carrying bulk cargo owned by one interest is a simple matter. In the case of a large steamer, however, loaded with a miscellaneous cargo owned by hundreds of different shippers or consignees the stating of the general average is a task involving tremendous detail. The final average adjustment, as published and distributed to underwriters and shippers for their examination in

[3] William D. Winter, "Marine Insurance," p. 405.

such cases, sometimes occupies two or three volumes of 500 pages each.[4]

Disregarding a multitude of details and requirements to be found in an actual case, the following example should make clear the principles of a general-average adjustment. Suppose that the values of the three interests in a venture are:

Hull	$100,000
Cargo	150,000
Freight (not prepaid or guaranteed)	10,000
Total	$260,000

Cargo valued at $26,000 is jettisoned (thrown overboard) as a general-average sacrifice. The contributions of the three interests would be as follows:

Hull (100/260 of $26,000)		$10,000
Cargo	124/260 (saved)	12,400
	26/260 (sacrificed)	2,600
Freight (10/260 of $26,000)		1,000
Total		$26,000

Each interest suffers a loss of 10 per cent of its value so that all are "placed in the same relative position."[5]

Relation of General Average to Marine Insurance. A general-average act calls for a general-average adjustment, regardless of insurance. The adjustment determines the losses of the parties to the venture, and if the parties are insured these losses will be payable by their insurers, to the extent that they are covered. Continuing the example, assume that each interest is fully insured and that each party (insurer and insured) enforces his contract rights literally, the hull being insured with the X company, the cargo with the Y company, and the freight with the Z company. The following payments would be made:

Y pays cargo interest	$26,000
Hull interest pays Y	$10,000
Freight interest pays Y	$ 1,000
X pays hull interest	$10,000
Z pays freight interest	$ 1,000

[4] *Ibid.*

[5] The sacrifice of cargo would carry with it a sacrifice of freight which, for the sake of simplicity, is not taken into account. The expense of preparing the general-average adjustments has also been disregarded.

By this process, the insurer of each interest has a net loss of the same amount as was incurred by that interest under the general-average adjustment. Actually, fewer transactions would normally take place. If the facts were as stated, Y would pay the cargo interest $26,000 and would collect directly from X and Z.

Marine Salvage

Salvage of a venture is usually arranged by the shipowner under contract, and the cost is borne in the same way as are general-average expenses.[6]

Implied Warranties

The mere making of a contract of marine insurance implies certain warranties by the insured. These warranties generally state (1) that the vessel is seaworthy, (2) that there will be no deviation from the agreed voyage, and (3) that the venture will be legally conducted. Winter includes a fourth, "prompt attachment of risk," though this seems to be covered by the warranty of no deviation. Breach of any of these warranties will render the contract void, and later conformity to the warranty will not revive it.

Seaworthiness. Seaworthiness of a vessel (the warranty does not apply to cargo, as such) is reasonable fitness to survive the normal course of its contemplated use. It means more than being of proper construction and in good repair, for its equipment must be adequate; it must be properly manned, furnished, and provisioned; and the cargo must be properly stowed and not too heavy for safety.

The implied warranty relates to the condition of the vessel at the inception of a contract, insuring a specified voyage. It is applicable alike to hull, cargo, freight, or other insurance. It is not applicable to hull insurance written under a time policy, and, unless the cargo owner charters the vessel, is regularly waived by express provision in a cargo policy. In all cases, however, the insured under a hull contract is obligated to use due diligence to see that the vessel is in seaworthy condition.

Deviation. Winter states the conditions, violation of which will avoid the contract, as follows:[7]

[6] See Winter, *op. cit.*, pp. 430ff.
[7] *Ibid.*, p. 168.

> The implied conditions with respect to deviation require that the voyage be commenced within a reasonable time, that it be pursued over the usual and direct route between the termini, and that the cargo be discharged from the vessel with customary dispatch. If it is a well-established usage of a particular voyage that certain places be used as ports of call, the use of such ports will not be considered a deviation. If the policy provides that the destination shall be ports in a given locality, they must be visited in their geographical order unless there be well-established usage to the contrary. If, on the other hand, the ports of destination are specifically enumerated in the policy, they must be visited in the order named.

Deviation is excusable and will not avoid the contract where necessary for the safety of the vessel, for saving human life or aiding a ship in distress where human life may be in danger, where necessary to obtain medical or surgical aid for a person on board, or where caused by barratry if barratry is insured against.

In practice, most cases of deviation will not avoid the contract since, in addition to the types of deviation excusable as a matter of law, deviation is usually permitted by contract provisions, the insured being obligated to notify the insurer of any deviation and to pay any additional premium required.

Legality. The conduct of the venture and its purpose must be legal under the laws of the country where the contract of insurance is made, including applicable provisions of international treaties to which the nation is a party. This warranty may not be waived. Ventures illegal under the laws of other nations are not barred—for example, if a vessel were insured under a contract made in another country, the contract would not be avoided by activities such as smuggling goods into the United States, contrary to our revenue laws, or landing merchandise the importation of which is prohibited.

Exclusions

The marine-insurance contract being so often a tailor-made contract, the extent to which losses are excluded from its coverage varies greatly. Exclusion of losses means a lower premium rate, but the hazard of the excluded losses is accepted by the insured. The insurer regards some types of loss as impracticable to insure and may exclude others by preference or in order to offer insurance at a lower rate. One general class of exclusion is that of particular average, in whole or in part.

F.P.A. Clauses. *A free-of-particular-average* (F.P.A.) clause ordinarily takes one of two forms. The free-of-particular-average-American-conditions clause reads: "Free of particular average unless caused by stranding, sinking, burning, or collision with another vessel." This means that the insurer agrees to pay particular average only when it is due to one of these causes; the insured bears all other particular average. The other form, the free-of-particular-average-English-conditions clause, reads: "Free of particular average unless the vessel or craft be stranded, sunk, burnt, or in collision."[8] Under this clause, the insurer is liable for particular average if, during the voyage, any one of the four casualties has occurred, regardless of its causal connection with the loss. The American clause is logical, the English speculative, but the latter has come to be generally used.

Memorandum. More carefully thought out is the *memorandum* clause, of which the following, formerly used in an American cargo-insurance contract, but now obsolescent, is an example:

> It is also agreed, that bar, bundle, rod, hoop and sheet iron, wire of all kinds, tin plates, steel, madder, sumac, wicker-ware and willow (manufactured or otherwise), salt, grain of all kinds, tobacco, Indian meal, fruits (whether preserved or otherwise), cheese, dry fish, hay, vegetables and roots, rags, hempen yarn, bags. cotton bagging, and other articles used for bags or bagging, pleasure carriages, household furniture, skins and hides, musical instruments, looking-glasses, and other articles that are perishable in their own nature, are warranted by the assured free from average, unless general; hemp, tobacco stems, matting and cassia, except in boxes, free from average under *twenty per cent* unless general; and sugar, flax, flaxseed and bread, are warranted by the assured free from average under *seven per cent* unless general; and coffee in bags or bulk, pepper in bags or bulk, and rice, free from average under *ten per cent* unless general.
>
> Warranted by the insured free from damage or injury, from dampness, change of flavor, or being spotted, discolored, musty or mouldy, except caused by actual contact of sea water with the article damaged, occasioned by sea perils. In case of partial loss by sea damage to dry goods, cutlery or other hardware, the loss shall be ascertained by a separation and sale of the portion only of the contents of the packages so damaged, and not otherwise; and the same practice shall obtain as to all other merchandise as far as practicable. Not liable for leakage on molasses or other liquids, unless occasioned by stranding or collision with another vessel.

[8] There are variations in the wording, but the examples cited are typical.

The items and percentages may vary, but the basic purpose of this clause was to divide the losses that should be insured against from those that should be borne by the insured. The provisions for excluding particular average from coverage unless it amounts to a specified percentage of value, when the entire loss is paid, are franchise provisions, and the percentage specified is the *franchise.* If the words "which is deductible" follow the words "per cent" (or some equivalent expression is used), the insurer is liable only for the amount of loss *in excess of* the stipulated percentage.

The memorandum clause entirely excludes particular average of certain sorts; these come within the range of business risks properly borne by the insured.

F.C. & S. Clause. A typical *free-of-capture-and-seizure* clause as used in the hull contract excludes any claim for loss, damage, or expense caused by or resulting from capture, seizure, arrest, restraint, or detainment; all consequences of hostilities or warlike operations (whether there be a declaration of war or not); all loss, damage, or expense caused by any weapon of war employing atomic or nuclear fission or fusion; and the consequences of civil war, revolution, rebellion, insurrection, or civil strife arising therefrom, or piracy.

The effect of this clause is to free the insurer from liability for payment of losses due to war perils. Subject to special provisions, the war risk (in general that excluded by the F.C. & S. clause) may be covered by a war-risk contract.

S.R. & C.C. Clause. The following is an example of the *strikes, riots, and civil-commotions* clause found in most cargo contracts:

> Warranted free of loss or damage caused by or resulting from strikes, lockouts, labor disturbances, riots, civil commotions or the acts of any person or persons taking part in such occurrence or disorder.

The hazards excluded by this clause may usually be covered by attachment of an S.R. & C.C. endorsement.

Extension of Coverage

In the early days of marine insurance the hazards of loss to cargo envisioned by insurers and insureds were those encountered while cargo was in transit from the time of loading to the time of discharge. And since the shipper

delivered the goods to the ship and the consignee took delivery from the ship normally after a continuous voyage, their insurance needs were reasonably well met.

With the development of transportation, goods came to be shipped from inland points to other inland points, the sea voyage being a connecting link between means of transportation on land. The goods were in control of the shipper only until delivered to the carrier at the shipper's place of business, and the consignee received them at his warehouse. To cover the entire trip, the *warehouse-to-warehouse* clause was devised and is a part of practically every cargo contract covering goods in packages. It covers from the "warehouse and/or store" where the transit commences to the "final warehouse," with a limitation of coverage to 60 days from the time of discharge from the ship.

In event of transshipment other than as above or of delay beyond the stipulated time limits "arising from circumstances beyond the control of the assured," the goods are "held covered," but the insured agrees to give prompt notice of such an event and to pay "a premium to be arranged."

Marine Extension Clauses. Commencing with the Second World War the congestion, and often disruption, of commerce by sea left shippers and consignees in the position of being unable to keep track of their shipments or to know when they would be forwarded or would arrive at destination. To give them insurance in spite of delays, transshipments, and changes of route, the insurers adopted a lengthy endorsement extending coverage to almost all situations that might arise.[9]

P.P.I.-F.I.A.

In some cases marine insurance is effected "policy proof of interest, full interest admitted." These words in a marine-insurance contract mean that the insurer admits that the insured has an insurable interest to the amount of insurance for which the contract is written. Such an admission would not be recognized as binding by a court and is in the nature of a gentlemen's agreement to eliminate the necessity of proving the interest at the time of loss-adjustment negotiations.

Valued Policies

It is customary to agree in advance on the value of the subject matter of a marine-insurance contract. This agreement, in the absence of fraud, is binding on insurer and insured. There are so many possible influences on the

[9] For the text of these clauses, see Winter, *op. cit.*, p. 163.

value of goods in the course of international trade that it is more practical to fix a value in advance than to attempt to assess it at the time of loss. Further, cargo is generally out of the control of the insured while covered by marine insurance, so that overvalued goods do not involve the moral hazard that would be incurred elsewhere. Overvalued ships do sometimes lead the owner to attempts to destroy them in order to collect the insurance money.

Basis of Valuation. Where a single shipment of cargo or a ship is insured, the valuation may be expressed as "valued at sum insured" or "valued at $. . . . . ." But under contracts providing insurance of a wide range of shipments, the actual shipments to be reported and insured as made, a basis of valuation is prescribed. Such a basis might be "valued at invoice cost plus 10 per cent plus prepaid or guaranteed freight," "valued at $. . . . . the £ sterling (or the franc) of invoice," or "highest market value attained during the insured voyage or at invoice plus 10 per cent, whichever is higher."[10]

Double Insurance

The term *double insurance* means insurance under contracts covering the same interest with more than one insurer. Under American contracts not having their inception on the same day, insurers cover in the order of the dates of the contracts until full coverage of the interest is accomplished. The premium on any insurance in excess of full coverage should be returned to the insured. If the contracts have their inception on the same date, each insurer contributes to a loss in the proportion that its insurance bears to the total insurance, and premium should be returned pro rata on any overinsurance. In Great Britain the latter rule is applied, regardless of the dates of the contracts.

Coinsurance

Even though no "coinsurance clause" appears in the marine-insurance contract, 100 per cent coinsurance is the rule both here and in Great Britain. Section 81 of the Marine Insurance Act states the rule: "Where the assured is insured for an amount less than the insurable value or, in the case of a valued policy, for an amount less than the policy valuation, he is deemed to be his own insurer in respect of the uninsured balance." If one were insured in the amount of $50,000 on an interest valued at $75,000, no more than two-thirds of any loss would be payable by the insurer.

[10] Valuation is a difficult subject. For fuller discussion, see Winter, *op. cit.*, especially pp. 92–93, 170–173, 265–268, 322, and 385.

In the case of partial loss (the only case to which coinsurance conditions apply) the practice is to ascertain the market price at the place of destination and time of arrival of undamaged goods of the same kind and quality. Then the price that the damaged goods would bring in the open market is found, often, if not always, by their actual sale. The difference (the amount of loss) is expressed as a percentage of the sound value. The amount paid by the insurer is that percentage of the value stated in the policy. For example, if a cargo were shipped with a stated value of $1,000 and sustained damage on the voyage, it might bring $600 on arrival. A quantity of similar goods equal to that shipped might be worth $1,200. There would thus be established a 50 per cent loss of value. Fifty per cent of the named value of $1,000, or $500, would be paid. The insured would sustain an uninsured loss of $100, the proportion of the loss which his declared value was short of the true value. In the rare case of overvaluation, the insured, under this practice, would receive more than his loss by the proportion of his overvaluation. If the market value of sound goods in the above case proved to be only $800, the loss in value of $200 would have been 25 per cent, and the amount paid $250.

Marine-insurance contracts are of infinite variety, in spite of their basic similarity. In the space here devoted to them, it has been possible only to give some notion of their general nature and their types, and to discuss some of the more important provisions.

QUESTIONS

1 Cargo insured under a marine-insurance contract is "valued at invoice cost plus 10 per cent plus prepaid or guaranteed freight." The entire cargo is lost by a peril of the sea. At the time of loss the invoice cost of the same goods at point of shipment has declined 20 per cent. On what basis will the amount of loss be determined?

2 The agreed value of a shipment of goods under a marine-insurance contract is $10,000. A partial loss of $2,000 is sustained. The amount of the insurance is $8,000. How much would the insured collect?

3 What loss is covered by a freight-insurance contract?

4 A fully insured hull owner, whose vessel is valued at $100,000, expends $5,000 in a fruitless but reasonable effort to save it from total loss. For what amount is the insurer liable?

5 What is general average? What is its relation to marine insurance?

6 A ship is insured for the voyage from Montreal to London. On the way down the St. Lawrence, the master discovers that the ship left port in an unseaworthy condition and returns to Montreal, where it is put in seaworthy condition. The voyage is resumed, and the ship is destroyed by a storm

on the Atlantic. What is the insurer's liability under the marine-insurance contract?

7 Under marine-insurance contracts embodying the memorandum clause quoted on p. 197 and covering the respective shipments for full value, a shipper of cheese, valued at $5,000, sustains a particular-average loss of $1,000; a shipper of flax, valued at $10,000, a particular-average loss of $900; and a shipper of rice, valued at $8,000, a particular-average loss of $600. How much would each be entitled to collect?

14
INLAND-MARINE-INSURANCE CONTRACTS

"Inland marine insurance" is a contradiction in terms, but its name is justified by the fact that, through its contracts, the practices of marine insurance have, in considerable measure, been extended to coverage of risks on land. Actually, it represents a combination of marine, fire, and casualty insurance, originally designed to provide on land transportation insurance similar to marine insurance, and later developed to provide all-risks insurance on property at fixed locations where there was special need for broader protection than could readily be obtained under available forms of fire and casualty insurance.[1]

Following the First World War, imaginative and enterprising underwriters, unhampered by rules and agreements to which fire and casualty insurance were subject, offered inland-marine contracts to cover risks where there was little, if any, transportation hazard. The all-risks type of contract and the highly competitive premium rates quoted led many insured to replace their fire and casualty covers with the broader contracts at low rates.[2] Inland marine insurance had particular appeal to risks with large stocks in warehouses or even in retail premises at several locations. All-risks coverage under a single-policy contract was simple and economical, alike for insurer and insured.

THE NATION-WIDE MARINE DEFINITION

Freedom and resulting intense competition led to writing insurance at reduced rates and to a great variety of contract provisions. Principally at the behest of insurers with inland-marine departments, the Inland Marine Underwriters

[1] For more extensive discussion of these points, see William H. Rodda, "Inland Marine and Transportation Insurance," chaps. 1 and 2. The writer of this chapter is much indebted to Rodda's text.

[2] It was said that inland-marine rates were sometimes lower than rates for fire insurance alone.

Association was formed in recognition of the need for sounder methods and reasonable uniformity of contracts. Fire and casualty insurers became more and more concerned over the inroads into their business and, with encouragement from the New York State Insurance Department, they and the inland-marine insurers held conferences to determine the field of inland marine insurance.[3] Finally, the New York Superintendent of Insurance issued a ruling defining the property insurable, and the circumstances under which property would be insurable, under marine and inland-marine contracts. This ruling was the precursor of the Nation-wide Definition and Interpretation of the Insuring Powers of Marine and Transportation Underwriters approved by the National Association of Insurance Commissioners in 1933 as a recommendation for adoption by the several states. It was adopted by 34 states[4] and by a majority of the insurers writing inland marine or marine insurance.

> It is important to note that this document was a definition and interpretation of the *underwriting powers* of marine and transportation underwriters. It specified what the insurance companies could write as marine or inland marine insurance. It made no distinction between ocean and inland marine. All insurance companies writing marine insurance were asked to become signatories to the Definition, and a majority of them did. The adoption of the Definition by a state insurance commissioner made it applicable to all companies regardless of whether they had become signatories.[5]

Because of its general terms and because the "definition" was to a considerable extent based on delineation of spheres of influence, its application was made subject to the rulings of a Joint Committee on Interpretation and Complaint. This committee dealt with requests for decisions whether specific property or specific situations justified coverage under an inland-marine-insurance contract, and also with complaints that such contracts had been written where they were not justified.

Experience with the definition for some 20 years and increasing variations adopted by the states led the National Association of Insurance Commissioners to adopt, at its June, 1953, meeting, a revised and broadened definition under the title "Nation-wide Marine Definition."[6] The new definition (slightly amended with some variations) has been officially adopted by 43 states but a few states have amended the Definition extensively.

The definition was designed to meet a practical situation and is, both in its

[3] Representatives of fire and casualty insurers were in the majority.
[4] Every state that adopted it later modified it in some degree.
[5] Rodda, *op. cit.*, p. 46.
[6] For the text, see *Proceedings of the National Association of Insurance Commissioners*, 1953, pp. 561–572, and inland-marine manuals.

original and present forms, somewhat in the nature of a treaty that is based on principle but gives recognition to *de facto* circumstances. The outstanding characteristic of property eligible for insurance under an inland-marine contract is mobility; hence, with the exception of certain fixed instrumentalities of transportation and communication (such as bridges and tunnels) and a few specified kinds of fixed property, only personal property, as distinguished from real estate, may be so covered.

The present definition states that "marine and/or transportation policies may cover . . ." (1) imports and exports wherever the property may be[7] and without restriction as to time, provided the coverage of the insurance contract includes hazards of transportation; (2) domestic shipments, provided the coverage includes hazards of transportation, subject to limitations on coverage permitted while not in transit; (3) bridges, tunnels, and other instrumentalities of transportation and communication; and (4) personal property floater risks, as listed. These types of property and condition are made subject to a multitude of qualifications that defy summarization. The definition is still somewhat indefinite and will continue to call for interpretation in specific cases.

The Joint Committee on Interpretation and Complaint has been superseded by the Committee on Interpretation of the Nation-wide Marine Definition, consisting of 15 members appointed by the National Association of Insurance Commissioners, who interpret the definition. Five members represent marine and inland marine insurance; five, fire insurance; and five, casualty and surety insurance. The committee considers questions on interpretation of the definition propounded by insurance departments or insurers and issues interpretations which may, or may not, be adopted by the departments. Since the passage of multiple-line legislation[8] authorizing one type of insurer to write all types of nonlife insurance, the Nation-wide Marine Insurance Definition[9] has lost much of its importance, but certain sections of insurance law, such as the rate regulations, still treat marine insurance differently from other property-and-liability-insurance lines.

THE INLAND-MARINE CONTRACT

All Risks

Inland-marine contracts typically contain language similar to the following: "This policy insures against all risks of loss of or damage to the above described property arising from any cause whatsoever except:" This language

[7] Imports not on consignment in importers' usual places of storage.
[9] See p. 190.

makes the policy an all-risks contract, but "all-risks contracts" do not cover all risks, and the exceptions as well as the exceptions to the exceptions are particularly important in inland marine insurance. For example, one contract, from which the introductory language quoted is taken, excepts "loss or damage occurring in course of transit to shipments . . . by mail *unless* registered first class." Only by careful reading of the individual contract, including its endorsements, can its exact coverage be learned.

While many inland-marine contracts are of the all-risks type, many are named-perils contracts which cover only the causes of loss listed in the form. Even these contracts, however, are broad because they include numerous perils.

Deductibles

Taking its cue from ocean marine insurance, and applying the lessons of its own experience, inland marine insurance makes considerable use of deductibles, particularly in connection with all-risks coverage. Deductibles help to distinguish maintenance costs from fortuitous losses, save the disproportionate expense of handling small losses, encourage the insured to use care, and make for application of premium to insurance against the more serious losses. Further to promote care by the insured, he may be required to agree that the amount of the deductible be solely at his own risk, no other insurance covering it being carried.

Proposals

In some inland-marine lines the insurer requires the prospective insured to complete and sign a *proposal* which, while not binding him to accept the insurance, serves both as a source of information to the underwriter and as a warranty (or representation) by the insured. In certain lines, only a statement in the nature of an estimate is required—though its accuracy is not warranted, the insured is stimulated to consider his exposure to loss, and the estimate furnishes useful information to the insurer.

Valuation

Some contracts are valued, especially those in lines, such as the insurance of fine arts, where the individual items of property may be unique and give rise to widely varying notions of value. The valued policy eliminates controversy and, since valuation is a part of the writing of the insurance, gives the insurer an

opportunity to inspect the property, to limit its exposure to reasonable values, and to insist on adequate valuation as a basis for adequate premium.

Some contracts provide for a definite method of determining value at time of loss, particularly those covering commercial property in transit, e.g., invoice value at time and place of shipment. Others specify or imply that the measure of loss shall be actual cash value at time and place of loss.

Coinsurance

Unlike the marine-insurance contract, the inland-marine contract carries no implied provision for coinsurance. Some inland contracts make express provision for coinsurance; others make no provision, though there may be a tacit assumption of full insurance to value.

Territorial Limits

Since inland marine insurance usually covers property in transportation or subject to transportation, since the insured requires protection throughout the area of his operations, and since hazards and premium rates are in considerable degree functions of the area covered, inland-marine contracts specify the limits of the territory within which they cover. That area may be narrow, as for example, a radius of 50 miles; it may be world-wide; or it may be any intermediate area. The coverage of an inland-marine contract is seldom limited to a specific location; generally it covers at any location within the territorial limits.

Protection of Property

An insured is obligated under any insurance contract to make reasonable efforts to protect insured property from loss. In the inland-marine contract that obligation is spelled out by the sue-and-labor clause, taken over from the marine contract.[9]

Bailees

Property insured under inland-marine contracts is frequently in the hands of carriers or other bailees who are responsible in considerable measure for its safety. To the extent that an insured agreed to give the bailee the benefit of

[9] See p. 190.

his insurance, the right of subrogation of the insurer would be defeated. To preserve this right, it is provided in the contract that the insurance shall "in no wise inure directly or indirectly to the benefit of any carrier or other bailee."

Similarly any waiver of the insured's rights of recovery against a third party would, to the extent of the waiver, defeat the subrogation right of the insurer and would relieve the insurer of payment of loss to the same extent. Some insurers go so far as to insert a clause in the contract making it void in the event of such waiver. But insurance contracts are adapted to the realities of customary release or reduction of liability by agreement between the insured and the bailee.

If there is a conflict between the insurance contract and the contract between the insured and the bailee, use is made of a *loan receipt.* Under the terms of this receipt the insurer lends the amount of the loss under the insurance to the insured, but does not pay the loss as such. It then makes claim against the bailee in the name of the insured, and if necessary sues in his name to enforce the claim. To the extent that recovery is had against the bailee, the loan is repaid; any part of the loan not so covered is forgiven.[10]

Loss of Parts

In case of a loss of a part of a set or of other property, it might be claimed that, because the remainder was valueless or of less than its proportionate value, the insurer would be liable for a total or disproportionate loss. Inland-marine contracts frequently contain clauses designed to limit the insurer's liability to a fair proportion of the total value of the set or to the value of the particular part of other property lost. For example, the loss of one cuff link of a pair valued at $100 would call for payment of $50. Similarly, loss to labels, capsules, or wrappers is limited to the amount sufficient to pay the cost of new ones and to recondition the goods involved in the loss.

Interpretation of the Contract

Should the inland-marine contract be interpreted in accordance with the rules applicable to marine-insurance contracts or those applicable to fire and casualty contracts? This question has arisen from time to time. The tendency seems to be to apply fire and casualty general rules, which are more favorable to the insured.

[10] For an extensive discussion of bailee risks, see Prentiss B. Reed, "Adjustment of Property Losses," chap. 16.

TYPES OF CONTRACT

No attempt will be made here to explain, or even to list, all inland-marine contracts. A few outstanding examples will be discussed as an indication of the sort of risk that may be covered by such contracts. It is intended to put the reader on notice of the kind of property or situation that should suggest inquiry into the possibilities of inland marine insurance. Lack of standardization and continual change make detailed discussion of contract provisions out of order in a general text.

The contracts written by inland-marine insurers may be classified broadly as *business* and *personal.* The former are written to protect businesses; the latter to protect individuals against personal loss.

Business Contracts

Business contracts include (1) transportation contracts, (2) contracts on instrumentalities of transportation, (3) floater contracts of various sorts, (4) bailees and bailees' customers insurance contracts, and (5) block contracts.

Transportation Contracts. Among business-insurance contracts those covering transportation hazards are of outstanding importance.

These contracts are written to cover shippers against loss of their property in transit, while in the hands of various transportation agencies, including the post-office department, and, subject to strict limitations, while in storage or after arrival in connection with transit. Such agencies have varying degrees of responsibility for the safety of property entrusted to their care for transportation, depending on applicable statutory and common law, standard receipts and bills of lading, and special agreements between shipper and carrier. The shipper collects his full loss (assuming that he has adequate coverage) from the insurer, which takes over by subrogation his rights against the carrier. He thus secures prompt payment of his loss without the negotiation and delay incident to collection from the carrier and is indemnified for any loss in excess of the carrier's liability or for which the carrier has no liability.

Another type of transportation contract covers the liability of the carrier to the shipper for loss to property in its hands for transportation. Losses may arise during transit or while held by the carrier awaiting, or after, transportation. While any type of carrier might purchase such insurance, it is written almost entirely, if not entirely, to cover property shipped by motor truck (*motor truck cargo insurance*) or by air (*air cargo insurance*). Somewhat analogous to this kind of insurance, though a direct property, rather than liability, cover,

is insurance covering the insured's property while in transit on his own trucks (*owner's goods on owner's trucks*).

Instrumentalities of Transportation and Communication. The contracts written to cover instrumentalities of transportation and communication are of the all-risks type. They may cover railroad rolling stock, bridges, tunnels, piers, wharves, docks, slips, pipe lines, power-transmission lines, telephone and telegraph lines, radio and television communication equipment in commercial use as such, and outdoor cranes, loading bridges, and similar equipment. Many of these items lack the mobility characteristic of most property eligible for coverage under inland-marine contracts. Their association with mobile property or thought lends some justification for including them, though perhaps tradition is the stronger reason. Business interruption insurance, as well as direct property insurance, is available with respect to most of these exposures.

Business Floaters. Certain business (or professional) property has, by its very nature, no permanent location. It is transported from one place to another and remains in one location only to be removed for operations elsewhere. Such property is insurable under inland-marine *floater* contracts. To be eligible for inland marine insurance, it must be movable, not where it is expected to remain indefinitely, and if insured, must be covered during transportation from place to place. Business floaters may cover equipment, contents or stock, goods held on consignment, or property sold under an installment-payment plan.[11]

Typical of the property insured under these contracts are equipment used by contractors; theatrical scenery and properties; salesmen's samples; clothing manufacturers' garments in the hands of contractors for processing; motion-picture films; property for sale in the hands of agents; property held by a dealer for sale and encumbered by a bank loan.

These contracts are not standardized and are written to suit the particular circumstances of each insured.

Bailees and Bailees' Customers Insurance. Bailees other than carriers are responsible to their customers only for loss to the customers' property due to

[11] See Rodda, *op. cit.*, p. 255. For discussion of the various contracts, see *ibid.*, pp. 255ff.

negligence of the bailee. What constitutes negligence depends on the circumstances under which they are entrusted with the customers' property. Typical of bailees offering their services to the public are warehousemen, laundrymen, dry cleaners, tailors, furriers and fur storers, and operators of cold-storage locker plants.

If the bailed property is eligible for inland-marine coverage, the bailee may insure against his legal liability for loss to the property under an inland-marine contract; otherwise not.

While insurance against legal liability would protect the bailee from immediate loss, his customers would hardly be satisfied with refusal to make good on faliure to return the property undamaged. As a matter of good business, the bailee must indemnify the customer for loss or damage incurred while the property is in his care, regardless of fault. He may make a valid contract with the customer limiting the amount of his liability, though many contracts purporting to limit liability are not valid.

Bailees' customers insurance, under which the bailee is the insured, provides coverage which indemnifies the customer for loss, satisfying the need of the bailee at once for liability coverage and for "good-will" coverage. The contracts vary in accordance with the type and operation of the particular bailee. For example, a contract with a laundryman does not cover goods accepted for storage; a contract with a fur storer does. If a tailor receives garments for cleaning and, in turn, sends them to a wholesale cleaner, his contract may be written to cover throughout the time during which they are out of the hands of the customer.

Block Contracts. The block contract protects the insured against all property risks in connection with the operation of his business—it represents as nearly complete (en bloc) coverage as is practicable. As elsewhere, there are exclusions and limitations, either to avoid noninsurable risks or to induce the insured to conduct his business along safe lines.

The original block contract was developed for jewelers. It covers the entire stock usual to the insured's business; property of customers in his hands for such work as repair, remounting, or cleaning; and property of others in the jewelry trade delivered or entrusted to him, to the extent of his interest in, or liability for loss to it. Within the territorial limits of the United States and Canada the property may be on the insured's premises or in the hands of messengers, salesmen, other jewelers, customers (on approval), common carriers, or some other person. This contract, therefore, includes some cargo insurance and bailee's customers insurance as well as insurance on the insured's merchandise on his own premises. The exceptions to the coverage,

and the exceptions to the exceptions, are many and detailed, but they are designed to leave an insured thoroughly covered if he conducts his business with reasonable care.

Losses are settled on the basis of actual cash value, subject to the usual limitation to the cost to repair or replace, but with the special limitation to "the lowest figure put upon such property in the Assured's inventories, stock books, stock papers or lists existing at the time the loss occurred. . . . Any antiquarian or historical value attaching to the . . . property shall be excluded from the estimate of loss. . . ."

This contract, written for an indivisible premium, is, if endorsed to provide for a deductible, an attempt to apply insurance efficiently to that part of an insured's risk where it is needed, in the light of an analysis of his business. An extensive signed proposal is required, on the basis of which the risk is underwritten and rated.

Similar to jewelers' block in purpose and method are the fine-arts-dealers' form and the more recently developed contracts for furriers and equipment dealers.

Radioactive Contamination Insurance. Recently radioactive contamination insurance has been made available for coverage of property eligible for inland-marine coverage. This insurance is written under a separate contract form affording no other insurance and only in conjunction with an inland-marine contract covering the property against loss by other perils.

Personal Floaters

The inland-marine-insurance contracts issued to families include the broad personal property floater and several more limited floaters.

Personal Property Floater. The personal property floater affords nearly complete protection against loss to one's personal property other than that pertaining to the insured's business or profession. A few years ago this policy was the most popular inland-marine-insurance contract, but many persons can now secure superior protection under Homeowners Form 5, which is described in Chapter 19 and which includes as one of its components a modified personal property floater.

The personal property floater provides all-risks protection on personal property located almost anywhere in the world. It is written for a stated

amount on "unscheduled personal property," i.e., property not specifically insured and listed on attached schedules. There are specific limitations on the amounts applying to stated kinds of intangible property or of property of concentrated value, and on "unscheduled personal property ordinarily situated throughout the year at residences other than the principal residence of the Assured." Additional amounts may be added to cover on "personal jewelry, watches, furs, fine arts and other property" listed on attached schedules, each item being separately insured. An amount in addition to the limit of $250 otherwise imposed "on any one loss of unscheduled jewelry, watches and furs" may be purchased, up to a limit of $1,000. Beyond the limit further insurance may be purchased, but only fire, extended coverage, or burglary and holdup.

The insured is required to declare the "approximate values" of his unscheduled personal property, listed by items that subdivide the property by classes, such as silverware and pewter, clothing, books, musical instruments, cameras and photographic equipment, and including an "all other" item. He must also declare what value of each item is ordinarily situated throughout the year at residences other than the principal residence. Inaccuracy in these declarations will not invalidate the contract, but they are regarded as bringing some pressure on the insured to buy larger amounts of insurance than he might otherwise do, and they are of some use to the insurer in underwriting the risk. It is said that rates for this insurance are based on an assumption of 80 per cent of insurance to value, but it is regarded as impractical to require a coinsurance or average clause.

Provision is made for coverage, "at the sole option" of the insured, of the personal property of others at the residences of the insured, as well as the personal property of servants of the insured.

A clause providing for a deductible of $50 from each loss to unscheduled property may be endorsed on the contract. With limitations, one group of insurers grants a credit for the deductible equal to 40 per cent of the premium for unscheduled property coverage. The deductible does not apply to loss by fire, lightning, windstorm, hail, explosion, riot, riot attending a strike, smoke, damage by vehicles or aircraft, theft, or several other listed causes of loss.

Other Personal Floaters. For persons who feel that their needs are more specific or who are unable or unwilling to pay the premium charged for the personal property floater there are various other personal floaters.

The *personal effects* floater covers such personal effects "as are usually carried by tourists and travelers, belonging to and used or worn by the Assured and/or his wife and their unmarried children permanently residing together." It does not cover "on the premises of the domicile" of the insured. The *per-*

sonal articles floater covers, wherever located, listed classes of property, each for a separate amount of insurance, and in consideration of a separate premium.

Other personal floaters cover broadly the sort of property indicated by their titles. Examples are the *camera* floater, the *musical instrument* floater, the *golfer's equipment* floater, the *fur* floater, the *silverware* floater, and the *stamp and coin collection* floater.

The development of inland marine insurance is symptomatic of a general tendency toward breadth and simplification of coverage. It represents steps toward the ideal of complete insurance under a single contract.

QUESTIONS

1 What purpose is served by the Nation-wide Definition?
2 In what respects do inland-marine-insurance contracts resemble ocean-marine-insurance contracts?
3 An insured who has lost one of a pair of cuff links makes claim for the full value of the pair, on the ground that the remaining link has no value for use. On what basis would settlement of such a claim be made?
4 A bailor insures against loss of property in course of transportation. A bailee insures against liability for loss to property in his custody. A bailee contracts for customers insurance. In each case, what are the rights, or obligations, of the insurer against, or to, the bailee?
5 What types of business might be interested in purchasing business floaters?
6 Would a jeweler with a jewelers' block policy require fire insurance on his property? Cargo insurance? Bailees' customers insurance?
7 Smith, in negotiating a personal property floater in the amount of $3,000, estimates value of his clothing as $500. Clothing located at his principal residence is stolen. He claims $650 under his insurance contract and proves that he has lost clothing of that value. How much may he collect?
8 An upholstered chair is shipped from the principal residence of an insured who has a personal effects floater. It is lost in course of transportation. May the insured collect? Had he been insured under a personal property floater, could he have collected?

15
LIABILITY AND WORKMEN'S COMPENSATION

Liability-insurance contracts and workmen's-compensation-insurance contracts will be dealt with in the next three chapters. They have developed out of economic and legal circumstances and concepts, an understanding of which is basic to an understanding of the contracts themselves. The present chapter is therefore devoted to the background and *raisons d'être* of these contracts.

LIABILITY

Negligence

A person (or organization) may assert that he has been injured in person or property by another and may claim damages as compensation for the injury. Whether he may enforce his claim and what, if any, damages will be assessed are questions to be determined under the law of negligence, a branch of the common law that has been considerably modified by statute. If the claimant can show that the defendant was negligent and that, as a direct result of his negligence, the claimant, who was not in any degree negligent, sustained injury, the latter is entitled to a judgment for damages. The defendant has committed a *tort*, a wrong; the claimant's right to redress is based on the law of torts, not on contract.

Negligence in its legal meaning consists of failure to use the care required by law for the protection of others. The care required is that of

> a person exercising those qualities of attention, knowledge, intelligence and judgment which society requires of its members for the protection of their own interests and the interests of others.[1]

[1] American Law Institute, Restatement, *Torts*, § 283(a) 1934.

> The standard to which the actor must conform is that of a reasonably careful person under the circumstances; in other words that which is customarily regarded as requisite for the protection of others rather than that of the average man in the community. The two are generally identical, but, occasionally, the actor in particular situations is required to exercise an attention which is far higher than that which is exercised by any but a few members of the community.[2]

One's degree of accountability often depends upon the status of the claimant, whether, say business invitee or trespasser. One must keep the premises in reasonably safe condition for business invitees. One has no duty of care with respect to trespassers but is not supposed to set intentional traps. If the trespasser is a child, however, the business-invitee standard may apply if there is maintained on the premises an "attractive nuisance" which children find it difficult to resist exploring.

A person is not responsible for pure accidents, e.g., acts of God, like a stroke of lightning, nor for the consequences of action in emergencies where there is no time to decide a better course.

If negligence results in unintended harm to another, the injured party has a right of action for damages.[3] The negligence, whether of omission or commission, must be the proximate cause of the injury.

> The doctrine of proximate cause as applied in insurance is derived from the doctrine as applied in the law of torts.* [*44 *Columbia Law Rev.* 768, fn. 7 (1944).] There are many judicial definitions of the term "proximate cause" in the law of torts, but the difficulty with them is that in large measure they have been formulated with the background of a particular case in mind. In general terms, I think of proximate cause in the law of torts as that cause (the negligent act) which, in its natural and continuous sequence of causes and effects unbroken by any independent intervening cause, produces the result (the damage or injury) complained of and without which the result would not have occurred; and under such circumstances that the result ought to have been foreseen or reasonably anticipated by a person of ordinary prudence in the exercise of ordinary care, or that some similar injury might result therefrom as a natural and probable consequence.[4]

In the usual case the plaintiff bears the burden of proving that the defen-

[2] *Ibid.*, § 289(i) (1934).

[3] See "Prosser on Torts," chaps. 5 to 9. This text is an authoritative treatment of all phases of the law of torts.

[4] George I. Gross, "The Doctrine of Proximate Cause," p. 3. See also pp. 54–56.

dant was negligent, but sometimes, citing the doctrine of *res ipsa loquitor* (i.e., the thing speaks for itself), the court will shift the burden of proof to the defendant. For example, a flowerpot may fall from the defendant's ledge. Such accidents do not ordinarily occur unless negligence is evident, and in this instance the defendant was in exclusive control of the agency causing the loss. Therefore the defendant may be presumed to be negligent. In most jurisdictions the plaintiff in a negligence action must himself be free from any negligence that may have contributed to the injury, the slightest degree of *contributory negligence* defeating his claim. His claim may also be defeated if it can be shown that he "assumed the risk" of injury, either expressly or by implication.

In some jurisdictions the harsh doctrine of contributory negligence has been modified to one of comparative negligence under which contributory negligence does not defeat the claim but is to be considered by the jury in fixing the amount of the defendant's liability. Even in the jurisdictions where the doctrine of contributory negligence has not been changed, there is an increasing tendency to overlook slight negligence on the part of the injured if the negligence of the other party is great. The majority of the courts regard contributory negligence as a defense with the burden of proof on the defendant. In some jurisdictions the doctrine of the *last clear chance* is recognized. Under this rule, even though the plaintiff was negligent, the defendant is liable if he had the last opportunity to avoid the injury by exercising reasonable care.

Special defenses may be available for governments and charitable institutions. Governments and instrumentalities of government have in the past been held immune to suits alleging liability for damages on the ground of *sovereign immunity,* but through development of the common law and by statutory enactment such immunity has been to a considerable extent broken down. *Claims acts,* particularly the *Federal Torts Claims Act* (few states have enacted such statutes), have provided general waivers of immunity; distinctions have been drawn between essential governmental and proprietary functions, the former being subject to immunity and the latter, functions that might be privately performed, not so immune; and the privilege of immunity has been gradually eroded by changes in judicial attitudes.

Certain nonprofit institutions, notably hospitals, have likewise been immune to liability suits, and the same tendency gradually to hold them responsible for negligence is apparent. Here much of the development of the law has been concerned with the question of vicarious liability, that of liability of the hospital for acts of personnel employed by the hospital or exercising their professional functions (as doctors or nurses) within the walls of the hospital.[5]

[5] For a useful discussion of immunity and vicarious liability, see Arthur F. Southwick, Jr., "Trends in Hospital Liability to Patients."

Vicarious Liability

Under the legal doctrine of *respondent superior* a person is responsible not alone for his own acts, but also for those acts of his employees, servants, and other agents that occur in the course of their employment. This is particularly true where direction of their manner and method of work is exercised. Where such direction is not retained, but a contract is made for certain work to be performed by a contractor in accordance with his own methods, he is an *independent contractor,* and his negligence will not ordinarily be imputed to the person for whom he performs the work. In some situations the duty imposed by law goes beyond that of exercising personal care in the selection of the independent contractor. Such cases often have to do with work that is dangerous to others or with maintaining land or structures in such a condition as to be unreasonably dangerous to others. In the instances in which this doctrine is applicable, the duty is said to be "nondelegable," and the person having the duty is not excused even though he is careful in his selection of an independent contractor to whom he entrusts the task of performance.

Under the common law parents are not responsible for the negligent acts of their children unless they are negligent themselves or an agency relationship exists. However, many courts have adopted the family-car doctrine under which the parent is responsible for the operation of the family car by any member of the family. Many states make the signer of a drivers' license application for a minor responsible for the operation of vehicles by that minor. In several states the owner of a vehicle is responsible for the negligent operation of a vehicle by any operator driving with the permission of the owner. The implications of such statutes extend far beyond the parent-child relationship.

Strict (or Absolute) Liability

In some situations one may be liable for damages irrespective of negligence. Examples are the keeping of dangerous animals; maintenance of a condition, or carrying on of an activity, of a highly dangerous sort; failing to observe the requirements of a safety-appliance law; employing child labor below the minimum age; or selling liquor to persons who become intoxicated by it. Persons or organizations may incur liability for injuries resulting from the mere fact of being responsible for the existence of these conditions or activities, in other words, subject to the rule of *strict,* or *absolute,* liability, under either common or statute law. The operation of enterprises using nuclear energy is a more recent example.

Sources of Liability

The sources of liability and of claims for damages under the law of negligence are many, and plaintiffs' attorneys are constantly seeking new ones, both in causes and results. The public has come to think of accidental occurrences in terms of damages, a development encouraged by big verdicts, some plaintiffs' attorneys, the sympathetic attitude of juries, and settlements that are often made to avoid further trouble. But in reading news of liability claims and suits, a careful distinction should be made between claims (injury, cause of injury, and amount of damages) and the final results of the cases. Claims are often made on the most tenuous grounds, and it is common practice to demand larger damages than one expects to recover.

Accidents on the premises of owners, occupiers, operators, or persons in control of property, or on adjoining ways, are a prolific source of claims alleging that the premises were negligently maintained, or that operations were not conducted with sufficient care, and that, as a result, the plaintiff was injured. Slippery floors, open doors of elevator shafts, objects falling from buildings, sharp projections, obstacles to be tripped over, all may give rise to allegations of liability. And occasionally claims are made without any grounds at all or fraudulently. Physicians, druggists, accountants, lawyers, or brokers may have claims made against them for injury to the claimant's person or finances due to alleged malpractice. Products of manufacturers, the merchandise carried by a department store, or the food purveyed by a restaurant carry with their sale the implied warranty of reasonable fitness for the purpose for which they are sold—and proof of a breach of the warranty may give rise to liability for damages.[6] Where damages are sought by persons who are not entitled to recovery for breach of warranty, or where there is no warranty, negligence in manufacture or preparation may give rise to such liability.

One's personal activities or situation may also give rise to claims. A claimant may allege injury by being hit by a golf ball; the milkman may claim that he was injured through a fall caused by tripping over roller skates carelessly left on the walk; even a friend may make a claim based on a slippery floor.

The ownership, maintenance, or operation of vehicles, particularly motor vehicles, is a potent source of claims, a fact that requires no demonstration.

Not only do these claims present the hazard of liability for damages; they lead to trouble and expense in investigation, negotiation, and defense. Even if a claim is groundless, and the defendant wins in court, it may entail enormous loss of time, worry, and financial outlay.

[6] In some jurisdictions purveying of food for consumption in a restaurant is held not to be a "sale."

And so on, through libel and slander, false arrest, entertainment activities, advertising, installation or construction work, spread of fire, attractive nuisances, damage to good will, assault, invasion of privacy—each of these topics might be expanded into an essay on liability.[7]

Contractual Liability. While one may not relieve another of his legal liability to a third party, one may, in many cases, validly agree to relieve him of the financial consequences. It is common practice for a buyer of a product to include in his order a *hold-harmless* clause, to the effect that acceptance of the order carries with it an agreement to indemnify the buyer for any damages that he may incur on account of defects in the product. A lessee may agree to indemnify a landlord for damages incurred in connection with leased premises. Hold-harmless clauses were discussed in some detail in Chapter 8.

The Law of Negligence and Justice

At present the economic consequences of accidents are distributed, in theory, on the basis of fault; in fact, on the basis of chance, trading, and the relative resources of claimants, claimees, and insurers.

The law of negligence, under which liability for these consequences is presumably determined, needs for its just application relatively simple situations. The facts surrounding an accident should be accurately ascertainable, the blame for its occurrence correctly assessable, and the parties equally able to present their cases. Actually, the facts are seldom known with even approximate accuracy, and consequently correct apportionment of blame is impossible. There is no precise standard for the determination of damages, and such damages as are recovered may be subject to attorneys' fees ranging from 25 to 50 per cent. Court congestion and time needed for appeal result in unconscionable delays. Antiquated legal doctrines and sympathetic juries defeat the ends of justice. Reasonably immediate settlement often can be had only at the price of agreeing to inadequate compensation, unless the claimant's injury is a minor one, when he may be overpaid if he deals with a financially responsible person or an insurer. And the negligence system may be made to yield splendid returns to rings of fakers, unethical attorneys, and unscrupulous doctors.

Where award or settlement is inadequate, the economic consequences are borne by the injured person, tradesmen whose bills he cannot pay, hospitals, doctors, and the community in general. Where it is excessive, it constitutes

[7] For an extensive discussion of sources of liability, see Reginald V. Spell, "Public Liability Hazards." In many cases the cause, as in libel, may be intentional rather than negligence, but a right of action for damages may lie.

unjust enrichment at the expense of individual defendants or of society in general through high insurance premiums.

In certain jurisdictions or in connection with certain types of accidents the amounts recoverable at law are subject to maxima which may limit recovery to something less than the money value of the injury suffered.

Disclosure of Insurance. It is generally agreed that a jury knowing that the defendant in a liability suit is insured against loss is likely to be more generous to the plaintiff in determining liability and in assessing damages. Introduction of evidence that the defendant is insured is inadmissible, and even mention of insurance by plaintiff's attorney is generally regarded as improper; either may be a cause for declaration of a mistrial unless the fact of insurance has a direct bearing on the issues. The high claim frequency in Massachusetts is probably due in part to general knowledge that residents must be insured[6] in order to register their cars.

Plaintiffs' attorneys make every effort to get the fact of insurance before the jury, if only by implication, and are often successful without violating the rule. In some circumstances and jurisdictions such evidence is admissible; its introduction is a matter of discretion with the trial court.

In line with this rule, the defendant may not, generally, introduce evidence of not being insured.

"Judgment-proof" Defendants. Persons with little or no income and no property often feel that they are "judgment-proof," that they need not fear liability or insure against it, since they have not sufficient means to satisfy a judgment. They should remember that some tort claims or judgments in tort cases are not dischargeable in bankruptcy proceedings.

Employers' Liability

Liability for damages of an employer to his employee is governed by the law of employers' liability, a special branch of the law of negligence applying to the relationship of employer and employee (or master and servant, as they are sometimes designated in law). Since the employer's liability is now largely governed by workmen's compensation laws (to be discussed shortly), only a brief statement of the principles and history of employers' liability law is warranted.

[6] See pp. 624–625.

Before 1837 there were no cases on the liability of a master to his servant, and it is evident from a reading of Lord Abinger's opinion in the case of *Priestly v. Fowler*[9] that the learned justice was shocked by the presumption of the employee who made a claim against his employer.

The employer owes certain duties of protection to his employees. If he neglects to use due care in the performance of these duties, he is liable for the injurious consequences of his neglect. They are:

1 To employ suitable fellow servants
2 To establish and promulgate proper rules
3 To provide a safe place to work
4 To furnish safe appliances
5 To warn of danger

However, in *Priestly v. Fowler* and later cases the courts developed special defenses available to employers that made it difficult, and sometimes impossible, for employees to secure judgments.

A line of precedents was established abrogating the principle of agency (the responsibility of an employer for the consequences of acts of his employees) in its application to claims of employees for injury due to acts of fellow servants (employees). On the ground that employees generally know their fellow servants better than the master knows his workers and could and should decline to work with careless fellow workers, it was held that it was unjust to charge the master with responsibility for injuries caused by fellow servants. The injured should make his claim against his fellow servant. This was the *fellow-servant* rule which was followed even when the fellow servant was a foreman, though later a counterdoctrine of *superior servant* was developed to hold the master liable when the injury was caused by the act of one in a supervisory capacity. Some courts applied the *vice-principal* rule, under which the employer was liable for injuries caused by failure of a servant to use due care in the performance of the duties of the employer who had delegated them to the servant.

The requirement that the employer provide safe conditions of work was in considerable part nullified, first by low standards of reasonableness in considering whether the conditions were reasonably safe and, second, by the judicial doctrine of *assumption of risk*. This doctrine held that the employee, in consideration of employment, rate of wages, or other inducement, assumed the risks of his employment. Employees were in some cases denied damages even when working conditions were in violation of specific safety statutes, if the condition causing the injury was obvious. In one case where the machine was not equipped, as the law required, with a means of shifting the driving

[9] 3 M. & W. 1 (1837).

belt to an idling pulley to stop the machine for cleaning, the employee was denied recovery.

These doctrines, with the harsh doctrine of *contributory negligence*, gave the injured employee a very limited chance to enforce a claim against his employer.

As economic and social conditions changed, the inequities created by the common law became a matter of increasing concern to state legislatures. State after state enacted "employers'-liability" statutes. Somers and Somers[10] report that by 1908 almost every state had such a statute. However, these laws were often limited to extra-hazardous occupations and at best chipped away at the common-law defenses, prohibited contracts between the employer and his employees absolving the employer from any responsibility for employee injuries occurring out of an industrial accident, and gave the dependents of a deceased worker the right to sue. Although these laws did improve the position of the worker to a limited degree, the fundamental problems outlined in the next section remained, and dissatisfaction continued.

Defects. The defects of the employers' liability system were ably summarized in a classic study, as follows:[11]

1 It is wasteful:
   (a) The state expends a large amount in fruitless litigation.
   (b) Employers spend a large amount, as the result of work-accidents, only a small part of which is actually paid in settlement of accidents claims.
   (c) The injured employees spend nearly half of what they get in settlements and damages to pay the costs of fighting for them.
2 It is slow; recovery is long delayed, while the need is immediate.
3 It fosters misunderstanding and bitterness between employer and employees.
4 It encourages both parties to dishonest methods.
5 Net damages when finally recovered by an employee often are not commensurate with his injury or his need.

Results. Legislative and judicial attempts to mold the common law into an adequate remedy were abortive. Experts representing all interests agreed that the system of employers' liability was basically wrong and that any sound solution of the problem of industrial injuries must provide for its abolition.

[10] Herman M. Somers and Anne R. Somers, "Workmen's Compensation," p. 21.
[11] Crystal Eastman, "Work Accidents and the Law," p. 206. Item 5 added by Blanchard.

Present Application. Broadly, the law of employers' liability still applies to those employer-employee relationships in which it has not been abrogated by the adoption of the principle of workmen's compensation. About 20 per cent of the civilian wage and salary workers are not covered under workmen's compensation and consequently must seek recovery under employers' liability.[12] In addition, some injuries and diseases suffered by covered workers are not included under workmen's compensation.

Two large classes of employees are still subject to the law of employers' liability, but in forms relatively favorable to them. They are railroad employees in interstate commerce and seamen. Both are protected by the provisions of the Federal Employers' Liability Act of 1908,[13] which is based upon the common law of negligence but which greatly liberalizes it in favor of the employee. A seaman, in addition, has a right to *maintenance and cure* (care) and to wages to the end of the voyage for which he has signed, if he becomes ill or is injured.

WORKMEN'S COMPENSATION

For reasons both of principle and expediency, workmen's compensation has superseded employers' liability. The chief justifications follow:

1. Hazards of industry are responsible for the occurrence of a large majority of industrial injuries; therefore industry should be compelled to bear any loss that may result.* [*The principal argument in support of workmen's compensation is based on the principle of fault but the old narrow interpretation recognizing only *personal* fault has been superseded.] The provable majority is so large and the determination of fault in the remaining cases is so difficult that expediency demands the extension of the principle to all injuries. Further, an industry which is not able to bear the loss occasioned by its injuries and which exists only by forcing others to bear the loss is parasitic, and its expenses of production are not a true measure of cost.

2. Any workable scheme of compensation necessarily involves medical and surgical care of the injured, and such care results in a net gain to individual industries and to society. Discarding of injured workmen is no more justifiable than a refusal to repair damaged machinery.

3. Society has accepted the idea that the needy should be cared for in all possible cases. Workmen's compensation is an application of this idea to a specific problem.† [†It should be recognized that compensation according to need is not justified by the argument that the industry is responsible for economic loss. For example, industry is responsible

[12] A. M. Skolnik, "Twenty-Five Years of Workmen's Compensation," p. 5.
[13] Made applicable to seamen by the Jones Act (1920).

for the cutting off of a workman's wages through accidental death but is not responsible in proportion to the size of the man's family. Compensation for dependents in proportion to their number can be defended only on grounds of expediency.]

4. The provision in workmen's compensation laws that an industry shall bear the burden of cost of its injuries does not mean that the burden will ultimately be borne by the employer as such. It does mean that the expense of producing any particular article will more accurately represent its real cost and that the selling price will be fixed accordingly. The loss from industrial injuries will be borne by the consumer of the commodity the production of which has occasioned it. If the inclusion of this item in the cost of production makes necessary such an increase that the selling price becomes prohibitive, the continued existence of the industry is justified only on grounds that would warrant governmental aid.[14]

Complete application of the newer idea would mean that an employee would be entitled, without consideration of personal fault, to indemnification for all economic loss, due to injury by accident or disease, that he might suffer because of his connection with an employment. In fact, limitations, justifiable and otherwise, have been placed on the employee's right to compensation.

All states of the United States have enacted workmen's compensation laws, and the federal government has enacted laws covering its own employees, employees of private employers in the District of Columbia, and longshoremen and harbor workers, but their scope and liberality vary greatly. By "scope" is meant the extent of their coverage of accidents or injuries to employees, and by "liberality" the extent to which economic loss is indemnified by provision for benefits.

Scope

Employees. No law covers all employees. Usually exceptions are domestic servants, farm labor, and casual employees. Employees of employers having less than a stated number of employees are excepted in many jurisdictions. Employees of public bodies are not covered by some laws. There is usually provision for voluntary acceptance of coverage.

Injuries. With unimportant exceptions the laws provide compensation for accidental injuries arising "out of and in the course of employment" without

[14] Ralph H. Blanchard, "Liability and Compensation Insurance," pp. 76–78. Minor editorial changes have been made, principally substitution of "injuries" for "accidents."

regard to fault. Many questions arise in the application of this standard. For example, is a heart attack incurred on the job covered under the act? Jurisdictions vary in the additional conditions (such as unusual exertion) that must be satisfied before this attack would be compensable. Back injuries pose a similar problem. Workmen's compensation is provided in lieu of the rights formerly accruing to employees under the law of negligence. Originally, compensation was provided, in most jurisdictions, only for injuries caused by accidents, but now all jurisdictions cover also either all occupational disease or diseases specifically listed.

Compulsory and Elective Laws. In the early days of the compensation movement there was considerable question whether it was constitutional to compel employers to pay compensation regardless of fault. At least one *compulsory* compensation law (that of New York) was declared unconstitutional on the ground that it did not "preserve to the employer the 'due process' of law guaranteed by the Constitution, for it authorizes the taking of the employer's property without his consent and without his fault."[15]

Because of this doubt, many laws were made, and 23 still remain, *elective*. Such laws provide, generally, that either employer or employee may elect not to come under their coverage, but that, in the absence of affirmative rejection, both are presumed to be subject to the law. If the employer elects not to come under the law, the employee may recover damages in accordance with the law of employers' liability, but the employer is deprived of his special defenses. If the employee so elects, the employer retains his defenses. There are no figures on the extent to which the rights of election have been exercised, but it appears to be negligible.

Benefits[16]

Disability. In cases of total disability, whether temporary or permanent, an injured employee is typically entitled to payment of 66⅔ per cent of his previous average weekly wages during disability, subject to various limitations

[15] *Ives v. South Buffalo Railway Co.*, 91 N.E. 431 (1911).

[16] Statements based on provisions of workmen's compensation laws are as of January, 1968, and apply to the laws of the 50 states, the District of Columbia, and Puerto Rico, the Longshoremen's and Harbor Workers' Act, and the Federal Employees' Compensation Act. A detailed analysis is available in "Analysis of Workmen's Compensation Laws," a report prepared periodically by the Chamber of Commerce of the United States, and in "Brief Summary of State Workmen's Compensation Laws," *Fact Sheet No. 10* published by the U. S. Department of Labor Bureau of Labor Standards. Any statement of benefits under workmen's compensation laws becomes rapidly out of date, principally because of liberalizing amendments.

and qualifications. Eight states vary the percentage according to the number of dependents. The percentages, including the effect of dependents' allowances, range from 50 per cent (one law) to 90 per cent (one law). These percentages are subject to maxima and minima. For example, the New Hampshire law provides for a maximum of $58 and a minimum of $15 for total disability (or actual wages, if less). This means that only persons earning $87 or less would receive the full 66⅔ per cent. The tendency of the weekly maxima to lag behind increasing wages is one of the most criticized features of workmen's-compensation statutes. In six jurisdictions the weekly maximum is still below $40, including dependents' benefits. On the other hand, seven states now automatically adjust their weekly maxima as average weekly wages increase. The median weekly benefit is $55, the lowest maximum being $35 and the top maximum in any law other than the federal law being $150 plus $2.30 for each total dependent.

Many laws have no limitations on the length of time during which benefits will be paid or on the aggregate amount payable in permanent total-disability cases but 21 laws have one or the other limitation, or both.

Payments in case of temporary partial disability are proportioned to the extent of loss of wages. In case of permanent partial disability, such as that caused by the loss of, or loss of use of, a part of the body, payments are, under practically all laws, based on schedules providing for payment of the percentage of wages granted for total disability, but during a specified period, regardless of actual loss of earning power. There are wide variations in the payments for scheduled injuries. For example, the loss of an arm at the shoulder will entitle the worker to 175 to 500 weeks of compensation depending upon the state law. The purpose in ignoring actual earning-power losses is to encourage the injured worker to return to work.

Waiting Period. Except in one state, disability benefits are subject to a waiting period immediately following the inception of disability, during which no benefits are payable. The period is typically 7 days and never exceeds this amount. Most laws provide that, if disability continues beyond a specified period, compensation will be paid for the waiting period. This *retroactive period* varies from 5 days to 6 weeks.

Medical Expenses. Injured employees are entitled to medical care, as much as is necessary under about four-fifths of the laws, but subject to limitations of time, cost, or both, under others. Where the law imposes limitations, employers or their insurers often, for humanitarian or practical reasons, provide care beyond that required by the law.

Death. On death of an injured employee, benefits are payable to surviving dependent, widows and children below a stated age often being presumed to be dependents, with others to some degree eligible on proof of dependency. In most laws the maximum percentage of wages payable to dependents is the same as is payable in case of total disability. In a majority, a widow or child alone receives less than the maximum, with provision for higher compensation where there are two or more dependents. There are maxima and minima per week, and maximum aggregate amounts, though a few laws place no limit on aggregate amount. Benefits to a widow cease on remarriage, with provision in some laws for payment of a lump sum at that time. Benefits on account of children cease at a specified age. Burial allowances, up to a maximum of $200 to $1,000, are also paid.

Rehabilitation and Reeducation. Account is taken in many laws, or in the activities of administrative bodies, of the need for rehabilitation or reeducation of workers whose disability may have terminated or may have resulted in loss of ability to pursue their former work. Some states have established special funds for rehabilitation of the industrially disabled, some provide for maintenance allowances during training, and all have accepted the provisions of the federal Vocational Rehabilitation Act, which provides for technical and financial aid to the states to establish programs for counseling and guidance, training, and placement services. While the terms "rehabilitation" and "reeducation" are not mutually exclusive, the former means primarily bringing the injured worker back, as far as may be, to his position before the injury; the latter, training him for new work to which he may be suited.

Mental therapy may be indicated in the case of a worker whose disability has left him in a hopeless frame of mind; or physiotherapy for one whose disability has resulted in muscular difficulties. A man who has lost a hand necessary to his former occupation may be trained to an occupation requiring only one hand.

Work of this sort is often undertaken by employers or insurers aside from any requirement of law.

Despite the many accomplishments in this area it is generally agreed that the number of workers who receive rehabilitation services is small relative to those who could benefit from these services. More states need special provisions in their laws relative to rehabilitation, and some states with such provisions need to administer them more effectively.

Administration

Except for five laws, the administration of workmen's compensation acts is confined to specially designated individuals or commissions. In the five

states, administration is in the hands of the courts. Provision is made for informal (as compared with court) procedure in the interest of getting the facts with a minimum of red tape. While attorneys may appear for claimants, they are usually not necessary, and their fees are limited. Appeals may be taken to designated courts, in many states only on questions of law, and provision is made for expediting them. Under almost all laws appeals are decided by the court without a jury.

The purpose throughout is to give expeditious effect to the provisions of the law with a minimum of technicalities, trouble, and expense. Unfortunately, although the situation is much improved over that under employers' liability, contested cases are still too common, resulting in delays and costs for injured employees.

The expense of administration under about one-half of the laws is assessed against insurers and self-insurers; in other jurisdictions, the state appropriates funds for administrative expenses.

Extraterritorial Effects

Under some circumstances the law of a state may be applicable to an injury incurred in another jurisdiction. A worker may even have a choice of proceeding under the law of either of two states. For example, an employer domiciled in state A may employ a resident of that state on a job being carried out in state B, where he is injured. The employee may have a choice of claiming compensation under the law of either state. If well advised, he will naturally choose the more liberal law. What the decision as to extraterritorial applicability will be in a particular case may depend on the provisions of the laws, their interpretation, the place of employment, the nature of the work, the place where the contract of employment was made, the residence of the employee, or the place of business of the employer.

Second Injuries

A worker who has incurred permanent partial disability may become permanently totally disabled by reason of a second injury which, in itself, would result only in partial disability. If the employer in whose employment the second injury was incurred were required to pay compensation for total disability, he would be unjustly treated and would presumably be unwilling to employ persons already partially disabled. Consequently, the employer is, under all but four laws (Georgia, Louisiana, Nevada, and Virginia), responsible only for compensating the employee for the disability caused by the second injury.

Special state funds have been created to provide for payment of the addi-

tional compensation due the worker. Many funds limit coverage to cases where a worker who had already suffered the loss of one member such as an arm injures another member so that the total effect of the second injury is much greater than the second injury alone. A few broad funds cover all cases involving pre-existing impairments. These *second-injury funds* are commonly financed by requiring the employer or his insurer to contribute a lump sum to the fund in each case of death of a workman who has no dependents but whose dependents would have been entitled to compensation had they existed. In some states insurers and "self-insurers" are taxed, or legislative appropriations are used, to support the fund.

Insurance Requirements

Merely making an employer liable for compensation is not sufficient protection for the worker. Provision must be made for financial ability to meet the liability, which may continue over a long period and involve amounts far beyond the resources of many employers.

Under all but one law employers are required to insure their liability, though under all but six of these laws an employer may, on furnishing proof of his own financial responsibility, be exempted from the requirement. Few employers are capable of furnishing such proof, and many who are financially responsible prefer to insure. Financial responsibility means not just a good credit rating, but sufficient financial strength to pay all compensation awards, which may run into huge sums. In practice, nearly all employers are insured.

Six jurisdictions (Montana, Nevada, North Dakota, Oklahoma, Washington, and Wyoming) have established state workmen's-compensation-insurance funds and granted them a monopoly position. Twelve others have established state funds that compete with private insurers.[17]

A complete summary of the provisions of workmen's compensation acts would require a volume. The aim here is to convey the purpose and general nature of these statutes.

QUESTIONS

1 What must be proved by a plaintiff in order to recover damages under the law of negligence? What defenses are available to the defendant?

2 What is the distinction between an employee and an independent con-

[17] Arizona, California, Colorado, Idaho, Maryland, Michigan, New York, Oregon, Pennsylvania, Utah, West Virginia, and Wisconsin.

tractor? What is the significance of the distinction in connection with claims for damages?

3 Jones, an automobile dealer who holds a franchise from Sun Motors, a manufacturer, sells a new car to Smith. Smith, while driving with his car, has an accident and suffers injury caused by the collapse of the right-hand front wheel. The wheel was supplied to Sun Motors by Moon Manufacturing Co., under a contract embodying a hold-harmless clause. To what claims against whom might this happening give rise, and on what grounds?

4 To what extent is the law of employers' liability still applicable to claims for damages by employees against employers?

5 A workmen's compensation law provides that a workman is entitled to 66⅔ per cent of his previous average wages in case of total disability due to injuries "arising out of and in the course of employment." What limitations may modify this general provision?

6 Brown, an employee of the Jones Manufacturing Co., loses the use of one eye, for which he is entitled to compensation. Later, while working for the Smith Manufacturing Co., he loses the use of the other eye, becoming totally disabled and again entitled to compensation. In what way is he compensated for each of these losses?

16
GENERAL-LIABILITY-INSURANCE CONTRACTS

All individuals or organizations are subject to the risk of claims for damages imposed upon them by law, and, in some cases, of claims for payment of damages imposed by law on others, liability for which has been assumed under contract. This risk is a double one: first, that of dealing with the claim—investigating, negotiating with the claimant, posting a bond if required, defending and paying expenses taxed in suits at law—whether or not the claim is honest or well grounded; second, that of paying the claimant, whether after a negotiated settlement or in satisfaction of a judgment obtained in court. Under a liability-insurance contract the insured is relieved of the financial consequences and most of the work and trouble of dealing with liability claims. This chapter deals with general-liability-insurance contracts, which cover most of the sources of liability not covered by the workmen's-compensation-insurance contract discussed in Chapter 17 and the automobile-liability-insurance contracts discussed in Chapter 18.

LIABILITY INSURANCE NOT CONTRARY TO PUBLIC POLICY

It might seem that legal liability would tend to promote care and that the mitigation of its burden would be contrary to public policy as tending to reduce that care. This contention has been before the courts, but they have declined to press the rule of public policy so far. They have pointed out that these contracts do not absolve the negligent party from his direct liability to the injured, and that it is no concern of the public what collateral contracts for indemnity may have been made. This view has been taken in a long line of decisions. It has also been held that there is an insurable interest to sustain such a contract.

DEVELOPMENT OF LIABILITY INSURANCE

Liability insurance is a relatively new line. Beginning in England in 1880, it was at first confined to the coverage of liability of employers for injuries to their workers—*employers' liability insurance.* For many years only this form of liability insurance was written, but gradually manufacturers and other business people began to realize the need of protection against their liability to the public arising out of their various operations, which exposed the public to risk of injury. With the development of industry, this type of cover has been in increasing demand, and an expanding line of policy forms has been developed to meet it. Recognition of the hazards of liability claims arising out of professional or personal (as distinguished from business) activities has also given rise to a wide variety of forms. The modern tendency is to relieve the insured of worry and risk by consolidating the insurance under one form, as far as possible.

BASIC POLICY OR JACKET

Except for a few provisions, the sense of which may be required by statute, general-liability-insurance contracts are not standardized by law. Most general liability insurance, however, is written by insurers who use the standard provisions developed by two rate-making organizations—the Insurance Rating Board, a stock-insurer organization, and the Mutual Insurance Rating Bureau.

Under the standard provisions program adopted in late 1966 the contracts consist of a basic policy or "jacket" to which one or more "coverage parts" must be attached.[1] The jacket contains information common to all general-liability policies. The coverage part relates these provisions to a specific type of insurance.

The jacket provisions are divided into four groups: (1) a general insuring agreement, (2) supplementary payments, (3) definitions, and (4) conditions.

General Insuring Agreement

Under the general insuring agreement the insurer agrees that in consideration of the premium and the statements made by the insured, it will provide protection in accordance with the provisions in the jacket, the declarations page, applicable coverage parts, and any special endorsements.

[1] The same jacket is used with the comprehensive automobile-liability-insurance and the garage-liability-insurance coverage parts described in Chapter 18. The format of a jacket plus a coverage part is not always used, but functionally the contract can be divided into these two parts.

Supplementary Payments

The insurer agrees that it will pay certain supplementary expenses in addition to any settlements or judgments and that these supplementary payments are not limited by the stated policy limits. These extra payments cover the following expenses:

1 Expenses incurred by the insurer in investigating the claim and defending the insured, all costs taxed against the insured in any suit defended by the insurer, and all interest on the *entire* amount of any judgment that accrues after entry of the judgment but before the insurer has tendered that part of the judgment covered by the policy limits.
2 Premiums on various court bonds that may be required—appeal bonds, release-of-attachment bonds (which may be required before the defendant can recover possession of goods that have been attached by the court to prevent their disposal before the judgment), and bail bonds. Attachment bonds are covered for amounts up to the policy limits. Bail-bond costs are limited to $250.[2] The insurer has no obligation to apply for or furnish these bonds—it promises only to pay for them.
3 Expenses incurred by the insured in order to provide first aid to others at the time of the accident. These payments do not depend upon the insured's liability.
4 Reasonable expenses incurred by the insured at the insurer's request, including his loss of wages or salary up to $25 per day because he is requested to attend hearings or trials.

Definitions

The definitions section defines terms that are common to all or most coverage parts. A few examples will illustrate their importance and their purpose.

General liability insurance, according to the coverage parts, protects the insured against sums he may become legally obligated to pay as "damages" because of "bodily injury" or "property damage" caused by an "occurrence." An "occurrence" is defined as an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended by the insured. Until recently, general-liability-insurance contracts covered only injury or damage caused by an "accident," which some courts interpreted to mean that the insurer was responsible only for sudden events. Coverage against occurrences that were not

[2] The contract covers the cost of bail bonds required because of a traffic-law violation arising out of the use of any vehicle to which the contract applies even if no accident has occurred.

accidents was provided by an endorsement to the basic contract. Injuries or damage resulting from repeated exposures, such as the consumption of contaminated food over a period of weeks, are now covered under the basic contracts. The stipulation that the occurrence must be unexpected by the insured cuts out losses that might reasonably be expected by the insured as well as those caused intentionally by him.

The use of "occurrence" in connection with the coverage of property-damage liability opens up the possibility that the contract covers injury to such intangible interests as patents and copyrights, which would not be injured by an accident. Consequently "property damage" is defined as injury to or destruction of *tangible* property.

"Damages" are defined to include, but are not limited to, damages for death and for care and loss of services resulting from bodily injury and damages for loss of use of property resulting from property damage.

"Bodily injury" means bodily injury, sickness, or disease. Certain injuries, such as those caused by libel, slander, false arrest, or invasion of privacy, are personal but not bodily. An endorsement is required if the insured wishes to have the contract extended to cover certain personal injuries.

Most general-liability-insurance coverage parts exclude liability assumed by the insured under any contract or agreement except an "incidental contract." Incidental contracts are defined to include any *written* (1) lease of premises, (2) easement agreement, except such agreements in connection with construction or demolition operations on or adjacent to a railroad, (3) agreement to indemnify a municipality if such an agreement is required by municipal ordinance and is not connected with work for the municipality, (4) sidetrack agreement, and (5) elevator-maintenance agreement.

Most coverage parts exclude occurrences associated with the "completed operations hazard" or the "products hazard." The completed-operations-hazard definition states that an operation is to be considered completed even if further service or maintenance work is required or if any defect or deficiency makes necessary some correction, repair, or replacement. This hazard is specifically defined not to include operations in connection with the transportation of property or the existence of tools, uninstalled equipment, or abandoned or unused materials. In other words, if someone is injured in an accident involving abandoned materials at a project site, this accident is *not* excluded under a completed-operations exclusion. The "products-hazard" exclusion can be invoked only if the bodily injury or property damage occurs (1) away from premises owned or rented to the named insured and (2) after physical possession of such products has been relinquished to others.

Another typical exclusion in the coverage parts eliminates coverage for property damage to (1) property owned or occupied by or rented to the insured, (2) property used by the insured, or (3) property in the care, custody,

or control of the insured or as to which he is for any purpose exercising physical control. The physical-control alternative in the third part of this exclusion is designed to exclude those cases in which the insured is controlling the property but without the owner's consent. The second and third parts of this exclusion do not apply to liability assumed under a written sidetrack agreement; the third part does not apply to damage arising out of the use of an elevator at premises owned by, rented to, or controlled by, the named insured. With respect to elevator-liability accidents, therefore, the exclusion applies only to property owned, occupied by, rented to, or used by, the insured. "Elevator" is defined to include almost any hoisting or lowering device except an automobile-servicing hoist, a hod or material hoist used in alteration, construction, or demolition operations, or small dumbwaiters. Escalators, for example, are elevators. If the insured wishes to cover his responsibility as a bailee, he may ask to have this exclusion modified, he may purchase special bailee liability insurance, or he may secure some protection under various property-insurance contracts; e.g., his fire insurance.

Subject to certain exceptions, all general-liability-insurance coverage parts exclude injury or damage arising out of the ownership, maintenance, use, loading, or unloading of any automobile. Automobile liability insurance can be purchased if the individual wants this protection. According to the basic policy, an "automobile" is a land motor vehicle designed for travel on public roads but does not include "mobile machinery." "Mobile machinery" in turn includes land vehicles, whether or not self-propelled, that either (1) are not subject to motor-vehicle registration, (2) are usually used on the premises (e.g., farm machinery), (3) are normally used away from public roads (e.g., contractors' bulldozers), or (4) are used to haul other equipment that form an integral part of that equipment (e.g., power cranes and shovels). Accidents involving this equipment are, therefore, covered.

Finally, the coverage parts apply only to injury or damage occurring during the policy period within the policy territory. The "policy territory" includes the United States, its territories or possessions, and Canada; international waters or air space except when travel to or from any other nation is involved; and anywhere in the world if the injury or damage arises out of a product sold for use or consumption within the United States, its territories or possessions, or Canada.

Conditions

The jacket contains conditions relative to premiums, inspection privileges, changes in terms, assignment, cancellation, other insurance, subrogation, the position of the insured following a loss, and the position of the claimant. Those conditions that contain some unusual features are described below.

Premiums. Premium rates for liability insurance are applied to various bases in order to arrive at the consideration, or premium, payable by the insured. The purpose of the insurer is to use a basis which measures the extent of its exposure to risk under the contract and which is practical of application in connection with the circumstances or activities of the insured. In many cases the premium base will be a figure (or figures) reflecting activities during the contract period. In such cases it is usual to arrange for the payment of an estimated advance premium, to be corrected at the end of the period in accordance with the actual figures, records of which the insured is required to maintain and furnish to the insurer.

Inspection. Where appropriate, as, for example, in the case of insurance covering manufacturing operations as if the premium is based on the insured's records, the insurer stipulates that it shall have the right to inspection or audit. A general-liability contract provides that the insurer shall be permitted *but not obligated* to inspect the named insured's property and operations at any time. Until recently the italicized phrase was not included in liability policies, and one workmen's-compensation insurer was held responsible for its failure to make a safety inspection. The insurer also may examine and audit the insured's books and records at any time during the policy period and any extension thereof and within three years after the final termination of the policy, as far as they relate to the premium bases or the subject matter of the insurance.

Other Insurance. The insurance is primary insurance unless otherwise stated, but when other valid and collectible insurance applies to the loss on the same basis, the insurer's responsibility is determined in one of two ways. If all other insurance provides for contribution by equal shares, all insurers with equal shares contribute equally until the insurer with the lowest limit has exhausted its limit of liability. The remaining insurers then share the remaining loss until another insurer exhausts its limit of liability, and so on. If any of the other insurance does not provide for contribution by equal shares, the insurer pays that proportion of the loss that its applicable limit of liability for such loss bears to the total applicable limit. To illustrate the difference assume that the insurer in question has issued a $25,000/$50,000 contract and the other contract has $50,000/$100,000 limits. If a claimant has suffered injuries valued at $36,000, the insurer would pay $18,000 under the first rule and $12,000 under the second.

Position of the Insured. *Notices.* The provision for notice of an accident (or occurrence) to the insurer or its agent is of particular importance in liability

insurance. The insurer should have an opportunity to investigate the event, secure evidence and witnesses, and determine reasonably what steps, if any, to take—whether to negotiate with the possible claimant, to authorize settlement within limits, or, if claim is made, to pay the claim or deny it and "stand pat." The notice must be in written form and given "as soon as practicable." It must contain

> particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances of the occurrence and the names and addresses of the injured and of available witnesses.

The insured should give notice of any occurrence out of which conceivably a claim might arise. He should not consider the probability of a claim nor accept any assurances that no injury or liability has been incurred.

In addition, if claim is made or suit is brought against the insured, the insured shall immediately forward to the insurer every demand, notice, summons or other process received by him or his representative. If the insured fails to comply with any of the requirements of notice, the insurer is relieved of liability under the contract.

Assistance and Cooperation. So much depends on the insured's help in connection with settlements and suits that failure on his part to assist the insurer is also ground for denying liability under the contract. The formal requirement follows:

> The insured shall cooperate with the insurer and, upon the insurer's request, assist in making settlements, in the conduct of suits, and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the insured because of bodily injury or property damage with respect to which insurance is afforded under this policy; and the insured shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendence of witnesses. The insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others as shall be imperative at the time of accident.

Action against Insurer. The contract provides that

> No action shall lie against the insurer unless, as a condition precedent thereto, there shall have been full compliance with all the terms of this policy, nor until the amount of the insured's obligation to pay shall have

been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and the insurer.

However, the insurer has contracted to give service and pay expenses in addition to paying damages. If it has denied all liability to the insured, action may lie for the recovery of the cost of defense and of other expenses, even though there is no "judgment against the insured" nor any "agreement of the insured, the claimant and the insurer."

Cases have arisen where the plaintiff has offered to settle for less than the policy limit, but the insurer, confident in its defense, has refused his offer. Later the case has been lost, and the judgment has exceeded the contract limit. It might seem unjust for the insurer to be required to pay on behalf of the insured only that limit and leave him to bear the excess, since settlement could have been made for the lesser amount, but under the terms of the contract he could not settle and claim reimbursement from his insurer. The courts have generally held in such cases that the insured must accept payment of the limit as the fulfillment of the insurer's obligation, if its refusal of compromise was merely a mistake of judgment without evidence of negligence or bad faith.

Position of Claimant. The claimant who seeks damages from the insured is in no sense a party to the liability-insurance contract, but the insurer has agreed with the insured "to pay" any damages, whether their amount is determined by judgment or agreement with the claimant. The insurer recognizes its obligation to pay in the following terms:

> Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this policy to the extent of the insurance afforded by this policy. No person or organization shall have any right under this policy to join the insurer as a party to any action against the insured to determine the insurer's liability, nor shall the insurer be impleaded by the insured or his legal representative.[3]
>
> Bankruptcy or insolvency of the insured or of the insured's estate shall not relieve the insurer of any of its obligations hereunder.

Declarations

A written application is not usually required for liability insurance, but there is included in the jacket a declarations section which, by acceptance of the

[3] In Louisiana and Wisconsin, the claimant may, under certain circumstances, bring suit against the insurer to determine the insured's liability.

policy, is made a part of the contract. These declarations are prepared from data submitted by the insured or his representative. They identify the named insured, his mailing address, the nature of his business, and whether he is an individual, a corporation, a partnership, or a joint venture. The beginning and ending dates of the policy period are stated, the hour of inception and termination being 12:01 A.M., standard time, on the dates stated at the insured's mailing address. All available coverage parts are listed but only those for which an advance premium is entered apply. Finally, the insured must describe any occasion on which similar insurance has been canceled during the past 3 years.

COVERAGE PARTS

The coverage parts available may be classified, first, according to whether they provide *business* or *personal* protection. Each of these two classes may be subclassified according to whether the insurance is *comprehensive*, covering practically all liability hazards arising out of specified broad situations or activities, or *selective*, covering hazards of specified relatively narrow circumstances or activities. The dividing line between comprehensive and selective coverages is admittedly sometimes difficult to draw.

Business-coverage Parts

Comprehensive general liability insurance is comprehensive business liability insurance. Less comprehensive but still broad are owners', landlords', and tenants' liability insurance and manufacturers' and contractors' liability insurance. More selective are completed operations and products liability insurance, contractual liability insurance, and independent contractors' liability insurance, whose names indicate the nature of their coverage. Examples of still more selective coverages are several professional liability contracts (nc coverage parts) for doctors, lawyers, insurance agents, and others.

Attention will be limited here to the first three coverage parts because of their relative importance, and particularly to comprehensive general liability insurance.

Comprehensive General Liability Insurance. The comprehensive general-liability-insurance coverage part contains separate declarations applicable only to that coverage part. These declarations state whether the insured has purchased bodily-injury-liability coverage, property-damage liability, or both; the limits of liability; the location of all premises owned by, rented to, or controlled

by, the named insured; and the hazards (premises-operations, elevators, independent-contractors, completed-operations, and products) that exist at the effective date, together with rating information.

The insurer agrees to pay on behalf of the insured all sums that the insured shall become legally obligated to pay because of bodily injury or property damage "to which this insurance applies." The insurance applies to the covers (bodily injury or property damage) noted in the declarations and to all sources of liability that are not excluded. The insurer has the right and the duty to defend any suit coming within the scope of the policy even if the allegations are groundless, fake, or fraudulent. It also reserves the right to make any investigation and settlement of any claim or suit that it deems expedient. However, it is not obligated to pay any claim or suit or to defend any suit after it has made payments exhausting its liability.

The exclusions noted earlier that apply to this coverage part include contractual liability, bailee liability, and automobile liability. Other important exclusions include aircraft and watercraft liability, liquor liability,[4] injuries to employees, and property damage to the named insured's products or completed operations themselves. This insurance does cover injuries arising out of a defective product; it does not cover the cost of providing a replacement.

The insured persons vary, depending upon the form of business organization. For example, if the business is a corporation, the insured persons are the corporation and any executive officer, director, or stockholder while they are acting within the scope of their duties. Real-estate managers for the named insured are also covered. Employees are covered only when operating on a public highway mobile equipment registered under a motor-vehicle registration law.

Bodily-injury payments are limited generally by "per person/per occurrence" limits of the type described in Chapter 11. However, the total liability of the insurer with respect to the completed operations-products hazard is limited to a specified aggregate amount. Property-damage payments are limited to a specified amount per occurrence, but an aggregate limit also applies with respect to some insureds, to certain operations by independent contractors, and to the completed operations-products hazard.

Owners', Landlords', and Tenants' Liability Insurance. The O.L. & T. coverage part contains declarations similar to those in the comprehensive general-liability-insurance part, but in this instance the only two hazards listed are

[4] Under special "dram-shop" statutes or common law, a person manufacturing, distributing, selling, or serving alcoholic beverages may be held responsible for losses caused by or suffered by an intoxicated person. In some cases the policy can be endorsed to cover this exposure.

premises-operations and elevators because these are the only two hazards covered. Otherwise this insurance is similar to comprehensive general liability insurance except that the company promises to pay injury or damages *arising out of the ownership, maintenance, and use of the premises and all operations necessary or incidental thereto.* This statement is so broad that it might be considered to be as liberal as comprehensive general liability insurance, but the exclusions state specifically that, in addition to the general-liability-insurance exclusions, this insurance does not apply (1) to the completed operations-products hazard or (2) to injury or damage arising out of structural alterations that involve changing the size of or moving other buildings, new construction, or demolition operations. The second exclusion can be deleted if the insured is willing to pay an extra premium. The completed operations-products liability exclusion cannot be removed. A separate completed operations-liability-insurance coverage part exists, but it is designed to be used when this is the only hazard the person wants to insure. Persons who seek this type of protection plus O.L. & T. liability insurance should purchase comprehensive general liability insurance.

Manufacturers' and Contractors' Liability Insurance. The M. & C. coverage closely resembles O.L. & T. insurance except that it is designed for a different type of insured whose premiums are determined on a different basis. Because contractors in particular may be engaged in many projects involving structural alterations, construction, and demolition, the exclusion of these sources of liability would greatly reduce the usefulness of this insurance. Consequently this exclusion is replaced by one that excludes operations performed for the named insured *by independent contractors* except maintenance and repairs at premises owned by or rented to the named insured or minor structural alterations at such premises. An independent-contractors'-liability-insurance coverage part is available to cover this exposure.

Premises Medical Payments Insurance. A coverage part that can be added to any of the three types of general liability insurance discussed above is premises medical payments insurance. Under this insurance the insurer promises to pay all reasonable medical expenses incurred by each person suffering bodily injury caused by an accident arising out of a condition in the insured premises or operations for which the insured had bodily-injury coverage under the policy. Only expenses incurred within one year following the accident are covered. The insurer will not inquire into the liability of the insured; this insurance is health insurance, not liability insurance.

The exclusions make it clear that this coverage applies to only two haz-

ards—premises-operations and elevators (and elevator accidents are not covered unless a special premium is paid). It does not apply to the completed-operations hazard, the independent-contractors hazard, or the hazards such as automobiles excluded under general-liability-insurance contracts. An important exclusion states that this insurance does not apply to bodily injuries to the named insured, employees in the course of their employment, tenants, and persons engaged in the maintenance, repair, alteration, demolition, or new construction at the insured premises. The protection is designed for customers, guests, and similar outsiders.

The limit of liability is stated on a "per person/per accident" basis. There are no subrogation rights.

Personal-coverage Parts

Although selective personal liability insurance is available, the *comprehensive-personal-liability-insurance* coverage part is so superior and so reasonably priced that it is the only form worthy of attention here. The declarations section names the insured and the location of his principal residence premises. It indicates whether the insured has certain unusual exposures, such as additional premises, business pursuits conducted at the premises, more than two full-time residence employees, or large outboard motors; an additional premium may be required in these cases. It also shows the limits of liability applicable to (1) liability payments, (2) medical payments, and (3) physical damage to property, a coverage that is described below. All these coverages are automatically included in the contract.

The personal-liability section provides the family with broad protection that is analogous to that provided a business under comprehensive general liability insurance. The most important exclusions are liability arising out of (1) premises, other than the insured premises, owned, rented, or controlled by any insured, (2) business pursuits, (3) aircraft, automobile, or watercraft,[5] (4) contract, except to any indemnity obligation assumed under a lease of premises or to liability of others assumed under any written contract,[6] (5) injury to employees covered under a workmen's compensation law (but domestic employees are usually not included under these acts), and (6) damage to property in the insured's care, custody, or control (including physical con-

[5] The watercraft-liability exclusion does not apply to rowboats and canoes, small sailing boats, or boats propelled by motors with less than a specified horsepower, and, except with respect to aircraft, this exclusion does not apply to injuries or damage occurring on the insured premises.

[6] This exception weakens the force of this exclusion considerably, but the exception does not apply to property damage caused by fire, explosion, or smoke or smudge caused by faulty operation of any heating or cooking unit.

trol). This last exclusion, however, does not apply to damage to the residence premises caused by fire, explosion, or smoke. Included, therefore, are such widespread occurrences as someone slipping on the front steps, a hunting accident, a bicycle accident, food poisoning, a dog bite, and a bonfire that gets out of control. The persons insured are the named insured and, if residents of his household, his spouse, the relatives of either, and any person under age 21 in the care of any insured. There is a single limit of liability per occurrence applicable to all claims associated with that occurrence.

The personal-medical-payments section corresponds to the business-premises-medical-payments coverage part. The bodily injury must be caused by an accident, not an occurrence; but otherwise the events that could result in a liability claim if negligence were involved correspond closely to those events that may result in medical payments. Negligence, however, is not required, and this insurance is technically health insurance. Any payments made under this section do not reduce the injured party's claim under the liability section. The limits of liability are stated on a "per person/per accident" basis.

Under the physical-damage-to-property section, the insurer promises to pay for or replace property physically injured or destroyed during the policy period by any insured. As in the case of medical payments, the issue of negligence is not raised. No property owned by any insured or household resident is covered. Children's intentional acts are covered, but not if the children are over 12 years old. The policy, therefore, will pay for the damage to a neighbor's window caused by a rock thrown by the insured's four-year-old son. The policy limit is normally $250 per occurrence.

EXCESS-LIABILITY INSURANCE

Excess-liability insurance covering losses in excess of certain stated amounts has become more popular in recent years. Two of the more popular forms of this insurance are umbrella liability insurance and personal catastrophe liability insurance.

Umbrella liability insurance, designed for business use, is first excess insurance over the insured's more conventional liability insurance of various sorts, such as general liability insurance, automobile liability insurance, aircraft liability insurance, and workmen's compensation insurance. Second, umbrella insurance covers hazards not covered under other liability insurance, such as liability for invasion of privacy in an advertisement or nonowned aircraft liability. A deductible of at least $25,000 per occurrence usually applies to this second group of hazards. The policy limits may be as high as $25 million or more per occurrence.

Personal catastrophe liability insurance provides similar protection for families. Examples of losses covered under this insurance but not under basic contracts include personal-injury claims based on false arrest and liability for automobile accidents occurring outside the United States and Canada. Major medical expense insurance, described in Chapter 22, is often issued as part of this insurance contract; the deductible is some large amount such as $10,000.

QUESTIONS

1 Brown is injured as a result of an accident on property belonging to Smith. Brown, believing that the property is owned by Jones, brings suit against Jones for damages. Jones, insured under a liability-insurance contract covering his property, forwards the papers served upon him to his insurer. What are the obligations of the insurer to Jones?

2 A claim for damages for bodily injury is made by Wood against Smith on the ground that Smith was negligent in leaving a rake on the sidewalk adjoining his house, and that Wood tripped over the rake and was injured. Smith's insurer is unable to effect a settlement with Wood, who sues and recovers a judgment of $12,000. The amount of the insurance is $10,000. Expenses of investigation and defense by the insurer amount to $2,000. What amount is the insurer obligated to pay?

3 A casual worker employed by Barnes at his home is splitting wood. Through his own negligence, he cuts his foot with the axe and requires medical attention costing $50. Barnes is covered by a comprehensive personal-liability contract which includes medical-payments coverage limited to $250. What is the liability of the insurer?

4 An insured under a liability-insurance contract permits a friend to store his automobile in the insured's garage, for which he receives $10 per month. The insured, while working in the garage with a blow torch causes severe fire damage to the friend's car. The friend claims damages from the insured. What obligation has the insurer?

5 An accident to a guest occurs in the house of Brown, insured under the comprehensive personal-liability contract. The guest is apparently unhurt and leaves the house. Brown gives the matter no further attention, though he was fully conscious of the occurrence. Two months later the guest makes a claim for damages on account of injury caused by the accident. Brown forwards the guest's claim to the insurer. What obligation has the insurer to Brown?

6 An insured under a liability-insurance contract says to a person injured

on his premises (covered by the contract), "This injury was entirely due to my negligence; I will make good any loss resulting from it." The injured person collects damages on the basis of this statement. To what extent is the insurer liable for the damages?

7 Cite three types of occurrence that would be covered under comprehensive general liability insurance but not under O.L. & T. insurance.

8 In what sense is an "occurrence" broader than an "accident"? A "personal injury" broader than "bodily injury"?

9 A store has a comprehensive-general-liability-insurance contract. What sources of liability remain uncovered?

10 What purposes are served by "umbrella" insurance?

17
WORKMEN'S-COMPENSATION-INSURANCE CONTRACTS

To protect employees under workmen's compensation acts it is not sufficient merely to make the employer liable to pay benefits and furnish medical care. The liability must be backed by adequate financial resources. Accordingly, all jurisdictions except Louisiana require the employer to insure his obligations through an insurer admitted in his state to write workmen's compensation insurance, or to furnish evidence of his own financial ability to meet such obligations. The requirements for permission to "self-insure"[1] are generally strict, and only employers with extensive financial resources qualify for it. Six states require the employer to insure. Many employers who could qualify as self-insurers prefer to insure, either as a matter of general policy or in order to obtain the services of the insurer (or of insurance intermediaries) in accident prevention or settlement of employees' claims.

State funds write all of the workmen's compensation insurance in six states and a considerable portion of the protection in 12 other states. Private insurers, however, write over 80 per cent of the premiums nationally. This chapter is limited to an analysis of the standard workmen's-compensation and employers'-liability-insurance policy used by these insurers. Although voluntary except for a few statutory standard provisions, the standardization in this line is complete.

THE STANDARD POLICY

Declarations

The declarations are a recital of the name of the insured, his status (individual, partnership, corporation, or other), and his address; the location of his operations; the policy period; the states to whose laws (workmen's compensa-

[1] The term *self-insurer* is used in connection with workmen's compensation to mean an employer who does not carry insurance, whether or not he makes special financial provision to meet the risk.

tion or occupational disease) the contract applies; certain rating and premium information; the limit of liability for the employers'-liability cover; and, optionally, certain underwriting information. These declarations describe the risk and give the details essential to adapting the general provisions to the individual risk. They are "made a part" of the contract, and it is formally stated that the insurer agrees to afford the insurance "in reliance upon the statements."

Insuring Agreements

The principal insuring agreement is a simple, direct, all-inclusive statement of the insurer's obligation:

> To pay promptly when due all compensation and other benefits required of the insured by the workmen's compensation law.

Although workmen's compensation laws are intended as a substitute for the law of employers' liability, there may be some residual liability under the law of negligence, and claims may be made for damages even though no such liability exists. An instance of such liability arose in New York when an employee collected compensation benefits for disability and damages for facial disfigurement caused by the same accident, on the ground that, while the compensation law covered disability, it made no provision for disfigurement. Under laws that do not cover occupational disease, or that limit such coverage, the employer may be subject to claims under the law of negligence. Consequently complete insurance coverage requires an employers'-liability insuring agreement, the standard provision for which is as follows:

> To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained in the United States of America, its territories or possessions, or Canada by any employee of the insured arising out of and in the course of his employment by the insured either in operations in a state designated in Item 3 of the declarations or in operations necessary or incidental thereto.

This agreement affords the liability insurance that is excluded from the coverage of the general-liability and other liability forms. The key words are "employee" and "arising out of and in the course of his employment."

Provision is made for defense, settlement, and supplementary payments in

practically the same terms as in the general-liability-insurance contract,[2] except that the wording is adapted to the combination of compensation and liability, and item (b)(4) of the liability form is omitted.

Clarifying definitions are included in the insuring agreements as follows:

> (a) Workmen's Compensation Law. The unqualified term "workmen's compensation law" means the workmen's compensation law and any occupational disease law of a state designated in Item 3 of the declarations, but does not include those provisions of any such law which provide non-occupational disability benefits.[3]
> (b) State. The word "state" means any State or Territory of the United States of America and the District of Columbia.
> (c) Bodily Injury by Accident; Bodily Injury by Disease. The contraction of disease is not an accident within the meaning of the word "accident" in the term "bodily injury by accident" and only such disease as results directly from a bodily injury by accident is included with the term "bodily injury by accident." The term "bodily injury by disease" includes only such disease as is not included within the term "bodily injury by accident."
> (d) Assault and Battery. Under coverage B [employers' liability], assault and battery shall be deemed an accident unless committed by or at the direction of the insured.

Definition (c) is necessary to make clear that the same injury cannot be both a *bodily injury by accident* and a *bodily injury by disease* and to eliminate any possibility of double liability for one injury.

The application of the contract is limited by the following clause:

> This policy applies only to injury (1) by accident occurring during the policy period, or (2) by disease caused or aggravated by exposure of which the last day of the last exposure, in the employment of the insured, to conditions causing the disease occurs during the policy period.

This rather awkwardly worded clause is a basis for determining the dividing line between the coverage of this contract and that of contracts with other insurers, self-insurance, or even noninsurance. So far as it applies to disease, it represents an attempt to simplify the coverage of occupational disease, which otherwise might involve several periods of coverage and make adjustment of losses difficult.

[2] See pp. 234.
[3] See pp. 595–597.

Exclusions

As to workmen's compensation, the exclusions from coverage are in line with the purpose of compensation—to give broad protection. The contract does not apply under either the compensation or the employers'-liability coverage

(a) to operations conducted at or from any workplace not described in Item 1 or 4 of the declarations if the insured has, under the workmen's compensation law, other insurance for such operations or is a qualified self-insurer therefor;
(b) unless required by law or described in the declarations, to domestic employment or to farm or agricultural employment.

Exclusion (a) excludes operations for which security for compensation is otherwise provided, and (b) eliminates the possibility of the contract constituting an election of compensation or otherwise providing automatic coverage for domestic, farm, or agricultural employees without the knowledge and assent of the insurer.

As to employers' liability, but not workmen's compensation, the contract does not apply

(c) . . . to liability assumed by the insured under any contract or agreement;
(d) . . . (1) to punitive or exemplary damages on account of bodily injury to or death of any employee employed in violation of law, or (2) with respect to any employee employed in violation of law with the knowledge or acquiescence of the insured or any executive officer thereof;
(e) . . . to bodily injury by disease unless prior to thirty-six months after the end of the policy period written claim is made or suit is brought against the insured for damages because of such injury or death resulting therefrom;
(f) . . . to any obligation for which the insured or any carrier as his insurer may be held liable under the workmen's compensation or occupational disease law of a state designated in Item 3 of the declarations, any other workmen's compensation or occupational disease law, any unemployment compensation or disability benefits law, or under any similar law.

These exclusions are self-explanatory, with the possible exception of (e), the purpose of which is to exclude claims brought at a time when it would be impractical to make an effective investigation and secure evidence and to enable the insurer to estimate its liabilities, after a reasonable time, without being faced by the possibility of new disease claims.

Neither in the insurance contract nor in compensation laws is there any exclusion of losses due to hostilities or nuclear energy. Since employers and their insurers would presumably be liable for compensation benefits even though the primary cause of disability or death were one of these hazards, the possibilities have given rise to concerned speculation and to suggestions that such losses should be borne by the federal government.

Conditions

Relation of Insurer and Beneficiary. The outstanding "condition" of the compensation-insurance contract is an amplification and confirmation of the insuring agreement to pay all benefits required by the workmen's compensation law. It consists of several paragraphs, the first two of which follow:

> The insurer shall be directly and primarily liable to any person entitled to the benefits of the workmen's compensation law under this policy. The obligations of the insurer may be enforced by such person, or for his benefit by any agency authorized by law, whether against the insurer alone or jointly with the insured. Bankruptcy or insolvency of the insured or of the insured's estate, or any default of the insured, shall not relieve the insurer of any of its obligations under coverage A [workmen's compensation].
>
> As between the employee and the insurer, notice or knowledge of the injury on the part of the insured shall be notice or knowledge, as the case may be, on the part of the insurer; the jurisdiction of the insured, for the purposes of the workmen's compensation law, shall be jurisdiction of the insurer and the insurer shall in all things be bound by and subject to the findings, judgments, awards, decrees, orders or decisions rendered against the insured in the form and manner provided by such law and within the terms, limitations and provisions of this policy not inconsistent with such law.

These provisions emphasize the fact that the contract is written primarily for the benefit of the employee and only incidentally to relieve the employer of financial loss.

Further provision acknowledges the position of the insurer as a part of the machinery for carrying out the purposes of the workmen's compensation law:

> All of the provisions of the workmen's compensation law shall be and remain a part of this policy as fully and completely as if written herein, so far as they apply to compensation and other benefits provided by this policy and to special taxes, payments into security or other special funds,

> and assessments required of or levied against compensation insurance carriers [insurers] under such law.

If there be any doubt of the complete subordination of the insurer to the compensation law, the following provision should remove it:

> Terms of this policy which are in conflict with the provisions of the workmen's compensation law are hereby amended to conform to such law.

Position of the Insured. But the insured employer is not free to disregard the penalties for violating the compensation law, even though the insurer may be obliged initially to pay such penalties. And he remains subject to other obligations imposed by the contract. The text of the contract provides that

> The insured shall reimburse the insurer for any payments required of the insurer under the workmen's compensation law, in excess of the benefits regularly provided by such law, solely because of injury to (a) any employee by reason of the serious and wilful misconduct of the insured, or (b) any employee employed by the insured in violation of law with the knowledge or acquiescence of the insured or any executive officer thereof. Nothing herein shall relieve the insured of the obligations imposed upon the insured by the other terms of this policy.

These "obligations imposed upon the insured" are similar to those imposed by the liability contract discussed in Chapter 16. They relate to the premium, maintenance of records, inspection of workplaces,[4] machinery, and equipment, examination and audit of records, notice of injury, notice of claim or suit, and assistance and cooperation. Unlike the practice under most insurance contracts, the rate or other basis for calculation of premium may be changed and become effective during the policy period; such changes are evidenced by endorsement.

Action against Insurer. Either the insured or a claimant has a right of action against the insurer under the employers'-liability-insurance part of the contract only under the usual conditions embodied in liability-insurance contracts.[5]

[4] Although the contract does not obligate the insurer to make safety recommendations, an Illinois jury has found an insurer liable for damages to injured employees and their survivors on the ground that it was negligent in its safety inspections. It was argued that the insurer had made an implied contract by virtue of its right to inspect and its advertisements of the effectiveness of its safety work. This decision was reversed on appeal but affirmed in 1964 by the Illinois Supreme Court.

[5] See pp. 238–239.

Cancellation. Cancellation is effected in the usual way on not less than 10 days' written notice, the period of notice running from the date of mailing. Provision is made for conforming cancellation of the compensation insurance to any provision of law applicable to it.[6]

Long-term Contract. It has been customary to write compensation insurance for a contract term of 1 year, a new policy being issued for each year's coverage. The present policy contract may be written for a minimum term of 1 year, a maximum of 3 years, or any intermediate term.

Limits of Liability. Since the only limits to the amount of workmen's compensation insurance are those appearing in the law, no limit is stated in the contract. A single limit to the amount of employers' liability insurance is stated in the declarations. This limit may be $100,000 or more. It is applicable to "all damages because of bodily injury by accident . . . in any one accident" or "all damages because of bodily injury by disease . . . sustained . . . in any one state" where the contract covers, the latter an aggregate limit for the contract period.

Other Insurance. Since compensation insurance is not written in terms of an amount of insurance, the usual provision for contribution to loss by other insurers is not adapted to it. It is provided that, if there is other insurance against a loss covered by the contract, the insurer will not be liable for more than the proportion of the loss that the loss for which it would have been liable, had no other insurance existed, bears to the sum of that amount and the amounts for which each other insurer would have been liable had each been the sole insurer.

For example, if there were a compensation loss of $1,000, and two outstanding contracts covering it, each insurer would pay 1,000/2,000 of the loss, or $500.

Miscellaneous. The usual provisions dealing with subrogation, waiver, estoppel, changes in the contract, assignment, and coverage of the insured's legal representative after his death are included.

[6] Workmen's compensation laws usually, if not always, require advance notice of cancellation to be given to a state adminstrative commission or official as well as to the insured.

QUESTIONS

1 An employee notifies his employer of an accident and makes claim for compensation. The employer takes no action on the notice or claim. The employee then presents his claim direct to the insurer. What is the obligation of the insurer?

2 An insured employer, in giving the insurer information for the Declarations, fails fully to describe his operations, omitting a small store where his products are sold to employees. An employee who works in the store is injured and claims compensation. Is the insurer obligated to pay any compensation due the employee?

3 An employer is insured with an insurer that becomes insolvent and is unable to pay his employees a part of the compensation for which it has become liable. What is the position of the employer?

4 During the term of a workmen's-compensation-insurance contract, the compensation law is amended to grant more liberal compensation to employees. Must the contract be amended to cover the increased benefits?

5 An insured is covered by a workmen's-compensation-insurance contract during the term Jan. 2, 1969, to Jan. 2, 1970. On June 2, 1969, a rate of premium differing from that charged on Jan. 2, 1969, goes into effect. How will this change affect his premium?

18
AUTOMOBILE-INSURANCE CONTRACTS

The insurance of automobile owners and operators against the hazards to which they are subject involves no principles not applicable to some one of the lines already discussed. But the application of these principles to automobile insurance is recognized as a specialized problem requiring a special contract. The potential losses include (1) claims for injuries or damages to others and (2) losses to the car itself.

TYPES OF CONTRACTS

In the past decade, the automobile-insurance field has become one of extreme diversity. Sales methods, types of insurer, rating methods, underwriting, promotion of safe driving, providing insurance for undesirable risks, limited and general compulsory liability insurance, plans for installment payment of premiums, all have influenced the provisions of the automobile-insurance contract. Most of the automobile insurance today is written by insurers who offer their own special brands, but insurers agreeing to use the standard products developed by the Insurance Rating Board and the Mutual Insurance Rating Bureau still account for a substantial share of the market. For this reason, and because the independent contracts are modeled closely after the standard contracts, attention here will be limited to the standardized products.

The most important standardized contracts are embodied in (1) the family automobile policy, (2) the special-package automobile policy, (3) the basic automobile policy, (4) the comprehensive automobile-liability policy, and (5) the garage-liability policy. The first three of these five contracts are usually combination contracts covering both the liability of the insured and loss to the insured automobile, but the physical damage insurance is often marketed separately from the liability insurance.

FAMILY AUTOMOBILE POLICY

The *family automobile policy* and the special-package automobile policy are designed for individuals (including sole proprietors insuring the car for business use) and families insuring private passenger cars—not commercial vehicles such as trucks or public vehicles such as taxis or buses.

Declarations

The contract embodies a series of declarations stating:

1 Name, address, and occupation of the named insured
2 Place where the car will be principally garaged
3 Policy period (12:01 A.M., standard time, effective date, to 12:01 A.M., termination date, at the address of the named insured)
4 Covers selected with applicable limits of liability (The contract lists the various covers that may be purchased and provides for choice among them by the insured.)
5 Pertinent detailed facts about the car
6 Purposes for which it is to be used
7 To whom, other than the named insured, physical-damage loss is to be paid "as interest may appear"
8 Facts of cancellation of previous insurance within 3 years

Liability Insurance

Under Part I, the contract affords liability-insurance coverage in the same general terms as other liability-insurance contracts, but the "injury," to be covered, must arise out of the "ownership, maintenance or use of the owned automobile or any nonowned automobile." Coverage is on an *occurrence* basis. The occurrence must take place within the United States, its territories or possessions, or Canada, or while the automobile is being transported between ports thereof. Provision for defense of suits, settlement of claims, and supplementary payments are almost the same as in other liability contracts.

Persons Insured. The named insured includes the individual named in the contract and his spouse. All of the following, however, are insureds under the liability-insurance section of the contract:

(a) With respect to the owned automobile,
    (1) the named insured and any resident of the same household,

(2) any other person using such automobile with the permission of the named insured, provided his operation or (if he is not operating) his other use thereof is within the scope of such permission, and

(3) any other person or organization, but only with respect to his or its liability because of acts or omissions of an insured under (a) (1) or (2) above;

(b) With respect to a nonowned automobile,

(1) the named insured,

(2) any relative, but only with respect to a private passenger automobile or trailer, provided his operation or (if he is not operating) the other use thereof is with the permission, or reasonably believed to be with the permission, of the owner and is within the scope of such permission, and

(3) any other person or organization not owning or hiring the automobile, but only with respect to his or its liability because of acts or omissions of an insured under (b) (1) or (2) above.

The insurance afforded under Part I applies separately to each insured against whom claim is made or suit is brought, but the inclusion herein of more than one insured shall not operate to increase the limits of the company's liability.

Use with Permission of Insured. Questions frequently arise as to what constitutes permission by the named insured to use the insured automobile. A person other than the named insured who uses the automobile should make sure that he has explicit permission, if he desires protection under the contract, though permission may at times be inferred. It may be argued, for example, that a named insured who has given explicit permission to another for use of the car at intervals over a considerable period of time has inferentially given permission for a continuance of the practice of borrowing the car. But such arguments are not to be relied upon.

Definitions. The following key definitions are essential to an understanding of this section of the contract; certain other definitions included in the contract are more technical in nature:

"relative" means a relative of the named insured who is a resident of the same household:

"owned automobile" means any of the following:

(a) a private passenger, farm or utility automobile described in this policy for which a specific premium charge indicates that coverage is afforded.
(b) a trailer owned by the named insured.
(c) a private passenger, farm or utility automobile ownership of which is acquired by the named insured during the policy period, provided
  (1) it replaces an owned automobile as defined in (a) above, or
  (2) the company insures all private passenger, farm and utility automobiles owned by the named insured on the date of such acquisition and the named insured notifies the company during the policy period or within 30 days after the date of such acquisition of his election to make this and no other policy issued by the company applicable to such automobile, or
(d) a temporary substitute automobile;

"temporary substitute automobile" means any automobile or trailer, not owned by the named insured, while temporarily used with the permission of the owner as a substitute for the owned automobile or trailer when withdrawn from normal use because of its breakdown, repair, servicing, loss or destruction;
"non-owned automobile" means an automobile or trailer not owned by or furnished for the regular use of either the named insured or any relative, other than a temporary substitute automobile;
"private passenger automobile" means a four wheel private passenger, or station wagon type;
"farm automobile" means an automobile of the truck type with a load capacity of fifteen-hundred pounds or less not used for business or commercial purposes other than farming;
"utility automobile" means an automobile, other than a farm automobile, with a load capacity of fifteen-hundred pounds or less of the pick-up body, sedan delivery or panel truck type not used for business or commercial purposes;
"trailer" means a trailer designed for use with a private passenger automobile, if not being used for business or commercial purposes with other than a private passenger, farm or utility automobile, or a farm wagon or farm implement while used with a farm automobile;
"automobile business" means the business or occupation of selling, repairing, servicing, storing or parking automobiles;
"use" of an automobile includes the loading and unloading thereof;
"war" means war. whether or not declared, civil war, insurrection, rebellion or revolution, or any act or condition incident to any of the foregoing.

Nonowned Automobiles. The "non-owned" provisions of the contract cover the insured owner of a car to some degree while using other cars. For

example, the named insureds are covered with respect to the occasional use of any type of automobile not owned or provided for the regular use of any insured; their resident relatives are afforded similar protection with respect to private passenger automobiles or trailers. But one who does not own a car may need insurance against claims for liability incurred in the use of others' cars, whether borrowed or hired. An employer may need protection against claims alleging injuries caused by the use of cars owned and operated by others but used in his interest. Insurance against such claims is provided under *nonowner* contracts.

Exclusions. The major reasons why the policy may not apply are that the automobile was being used as a public or livery conveyance,[1] the claim is for an injury to an employee (but that claim is covered if the employee is a domestic employee not covered under workmen's compensation), or the claim is for damage or destruction of property owned or transported by the insured or (except a residence or private garage) for property rented to or in charge of the insured.

Policy Limits. The policy limits are stated on a "per person/per occurrence" basis for bodily-injury liability and on a per-occurrence basis for property-damage liability. An automobile and a trailer constitute one automobile for the purpose of determining the application of these limits.

Other Insurance. If other liability insurance covers loss under this contract,

> the insurer shall not be liable under this policy for a greater proportion of such loss than the applicable limit of liability stated in the declarations bears to the total applicable limit of liability of all valid and collectible insurance against such loss. . . .

The liability insurance afforded under the contract to cover the use of a temporary substitute automobile, or the use of a nonowned automobile is declared to be excess over any other valid and collectible insurance available to the insured. For example, if the insured were an insured under a contract of insurance covering the owner of a borrowed car, his own insurance would be effective only after the owner's insurance on the borrowed car had been exhausted.

[1] A car pool would not ordinarily cause this exclusion to become effective.

Financial-responsibility Laws. Most states require the owner or operator of an automobile, under specified circumstances, to give evidence of financial responsibility to respond in damages as a condition of being allowed to register or to operate a car on the highways.[2] A policy of liability insurance conforming to the requirements of the statute is acceptable as evidence.

Provision is made in the contract that the insurance afforded under it shall comply with the provisions of any such law in any state or province to the extent of the coverage and limits required by the law, but not in excess of the limits provided in the contract. Since these laws are for the benefit of injured persons, the insurance contract is made an absolute agreement to pay any damages, even though the insured may have violated the contract. Consequently the insured agrees

> to reimburse the insurer for any payment made by the insurer which it would not have been obligated to make under the terms of this policy except for the agreement contained in this paragraph.

Medical Payments

Part II, the medical-payments section of the contract, is an agreement

> To pay all reasonable expenses incurred within one year from the date of accident for necessary medical, surgical, X-ray and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services:
> **Division 1.** To or for the named insured and each relative who sustains bodily injury, sickness or disease, including death resulting therefrom, hereinafter called "bodily injury," caused by accident,
>
> (a) while occupying the owned automobile,
> (b) while occupying a nonowned automobile, but only if such person has, or reasonably believes he has, the permission of the owner to use the automobile and the use is within the scope of such permission, or
> (c) through being struck by an automobile or by a trailer of any type;
>
> **Division 2.** To or for any other person who sustains bodily injury, caused by accident, while occupying
>
> (a) the owned automobile, while being used by the named insured, by any resident of the same household or by any other person with the permission of the named insured; or

[2] For further details, see pp. 621–622.

(b) a nonowned automobile, if the bodily injury results from
(1) its operation or occupancy by the named insured or its operation on his behalf by his private chauffeur or domestic servant, or
(2) its operation or occupancy by a relative, provided it is a private passenger automobile or trailer,
but only if such operator or occupant has, or reasonably believes he has, the permission of the owner to use the automobile and the use is within the scope of such permission.

The owner or operator of an automobile may well feel some satisfaction in being able to cover expenses due to disability or death occurring under circumstances connecting it with a car, regardless of possible liability. Medical payments insurance meets this need, though, to the extent that benefits are payable for which the insured would in any event be responsible (his own or those of dependents), or which are payable as a result of being struck by "an automobile" independently of any connection with the insured, it hardly has any connection with liability coverage. As stated in connection with general liability insurance, medical payments insurance is health insurance. Aside from contributing to his satisfaction, payment of expenses may ward off liability claims, saving the insured trouble and possibly resulting in lower over-all costs. However, if negligence is involved, the medical-payments benefit does *not* in most states reduce the insurer's liability under Part I.

Uninsured Motorists

Everyone is subject to the hazard of loss arising out of the ownership, maintenance, or use of an uninsured automobile by an uninsured motorist.[3] If the uninsured motorist is not liable for the loss, it falls on the injured party, and the absence of insurance is of no consequence. But if he *is* liable and has neither insurance nor resources to pay damages, the injured person has to bear a loss not properly his. The same result obtains if it can be shown that a "hit-and-run" automobile caused the loss. This situation has given rise to the *unsatisfied-judgment fund,* accumulated under governmental auspices, from which such persons injured in body or property may be compensated.[4]

Part IV of the family automobile policy, if purchased, protects the *insured* against loss for which the owner or operator of an uninsured automobile, including a hit-and-run automobile, is legally liable. It does so in the following agreement:

[3] An example of the curious language of insurance.
[4] See pp. 622–623.

> To pay all sums which the insured or his legal representative shall be legally entitled to recover as damages from the owner or operator of an uninsured automobile because of bodily injury, sickness or disease, including death resulting therefrom, hereinafter called "bodily injury," sustained by the insured, caused by accident and arising out of the ownership, maintenance or use of such uninsured automobile; provided, for the purposes of this coverage, determination as to whether the insured or such representative is legally entitled to recover such damages, and if so the amount thereof, shall be made by agreement between the insured or such representative and the insurer or, if they fail to agree, by arbitration.

The insurance covers only *bodily injury* caused by *accident.*

Persons Insured. The meaning of "insured" is narrower than under the liability section. The word means

(a) the named insured and any relative;
(b) any other person while occupying an insured automobile; and
(c) any person, with respect to whatever damages he is entitled to recover because of bodily injury to which this part applies sustained by an insured under (a) or (b) above.

Exclusions. To protect the interest of the insurer, payment will not be made in any case where the insured or any person entitled to payment shall, without the insurer's written consent, make any settlement or prosecute to judgment any action against anyone who may be legally liable for damages covered by this section of the contract. Payment will not be made so as to inure to the benefit of any workmen's-compensation or disability-benefits insurer, and the agreement to pay does not apply while the insured is occupying an automobile owned by the named insured or a relative or through being struck by such an automobile.

Limits. Limits of liability similar to those imposed under the bodily-injury-liability section of the contract are provided for, and it is provided that recovery under that section and under the uninsured-motorists section combined shall be limited to the larger amount collectible under either.

Other Insurance. If an insured suffers bodily injury while occupying an auto-

mobile not owned by the named insured, this uninsured motorists insurance is excess over any other similar insurance applicable to that automobile as primary insurance. It applies as excess insurance, however, only in the amount by which its policy limits exceed the limits of the other insurance. In all other situations it shares losses in the proportion that the limit of liability under this insurance bears to the sum of the limits under the other insurance. In applying this formula, however, losses in excess of the highest available policy limits are not counted. This is different from the situation under Part I, where the maximum amount of protection is the sum of the applicable limits of liability.

Arbitration. Provision is made for settlement of disputes as to the insured's entitlement to damages or the amount of such damages as follows:

> If any person making claim hereunder and the insurer do not agree that such person is legally entitled to recover damages from the owner or operator of an uninsured automobile because of bodily injury to the insured, or do not agree as to the amount of payment which may be owing under this Part, then, upon written demand of either, the matter or matters upon which such person and the insurer do not agree shall be settled by arbitration in accordance with the rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof. Such person and the insurer each agree to consider itself bound and to be bound by any award made by the arbitrators pursuant to this Part.

Reimbursement of Insurer. Since the purpose of this section of the contract is insuring recovery by the insured of damages to which he is legally entitled, payment of such damages by the insurer entitles it, to the extent of such payment, to any recovery from the uninsured motorist. Accordingly, it is stated that the insurer is so entitled and that the insured shall hold in trust for the benefit of the insurer all right to such recovery, which is in the nature of salvage. The insured is obligated to cooperate with the insurer in effecting recovery and to do nothing, after loss, to prejudice his rights.

Physical Damage

Unlike the possible liability loss, which is unlimited, loss to the automobile itself, to its equipment, or to personal effects in or upon it, and therefore any insurable interest in such property, cannot exceed the actual cash value of the property. The interest involved is primarily that of the owner, though

others may have an incidental interest, such as that of one who has a lien against the car. Part III of the family automobile policy covers this interest.

Comprehensive Cover. The broadest available coverage of loss to the automobile is afforded under the headings (1) Comprehensive (excluding Collision) and (2) Personal Effects. The insurer agrees:

> **(1)** To pay for the loss caused other than by collision to the owned automobile or to a non-owned automobile. For the purpose of this coverage, breakage of glass and loss caused by missiles, falling objects, fire, theft or larceny, explosion, earthquake, windstorm, hail, water, flood, malicious mischief or vandalism, riot or civil commotion shall not be deemed to be loss caused by collision.
> **(2)** To pay for loss caused by fire or lightning to robes, wearing apparel and other personal effects which are the property of the named insured or a relative, while such effects are in or upon the owned automobile.

Item (1) is a broad cover; item (2) is definitely limited to loss caused by fire or lightning, to property of the named insured or a relative, and to $100 of loss arising out of any one occurrence. The second sentence under (1) does not mean that, for example, breakage of glass caused by collision with another vehicle is not a collision loss. It merely states that, for the purpose of determining whether this loss is excluded under the comprehensive coverage, this loss shall not be deemed a collision loss. This is a liberal feature because as a result the loss may be covered under *either* the collision or the comprehensive cover, but not both. The insured will choose that cover that is most beneficial to him. For example, he may choose to consider the loss a comprehensive loss if he has that cover in order to avoid a collision deductible. If he has collision insurance but not comprehensive insurance, he will prefer to have the loss deemed a collision loss.

Collision. Available in addition to the comprehensive cover is *collision* cover, the two items, when taken together, constituting an "all-risks" cover. Insured loss under the collision heading is

> loss caused by collision to the owned automobile or to a nonowned automobile but only for the amount of each such loss in excess of the deductible amount stated in the declarations as applicable hereto. . . .
> . . . "collision" means collision of an automobile covered by this policy

with another object or with a vehicle to which it is attached or by upset of such automobile: . . . .

There are three reasons for offering these two covers separately: (1) many insureds who purchase comprehensive (or any of the special kinds of insurance dealt with below) do not desire to pay the rather large premium for collision insurance, especially since the amount of a collision loss in excess of $100 is deductible from income for federal (and perhaps state) income-tax purposes; (2) collision insurance is practically never written without a deductible provision;[5] and (3), from the point of view of the insurer, there are special problems involved in writing it.

Common deductible amounts are $25, $50, and $100; though provision is made for deductibles up to $1,000. It is impracticable to cover the multitude of small collision losses, such as dented fenders, scraped finish, or slightly bent bumpers. The expense of adjusting small losses, their frequency, and the tendency to exaggerate them have demonstrated the need of applying the deductible principle. The quoted rate, in at least one jurisdiction, for full-coverage collision is three times that for $50 deductible—but it is doubtful that it can be bought even at that price.[6]

Miscellaneous Covers. The following covers may be purchased separately, to cover loss to the owned automobile or to a nonowned automobile, although theft insurance or "combined additional coverage" may be written only in connection with fire insurance and for the same amount:

1 Fire, Lightning, and Transportation. Combined coverage of loss

caused (a) by fire or lightning, (b) by smoke or smudge due to a sudden, unusual and faulty operation of any fixed heating equipment serving the premises in which the automobile is located, or (c) by the stranding, sinking, burning, collision or derailment of any conveyance in or upon which the automobile is being transported on land or on water.

[5] Other covers are occasionally written with deductibles.

[6] *Convertible-collision* and *80 per cent collision coverage* (not generally available) are two other attempts to meet the problems. Under the former, the insured pays an initial premium (50 per cent of the full-coverage premium) and on making his first claim an additional specified amount (the remaining 50 per cent). Losses are then covered in full, but any loss prior to the first claim is not covered. This arrangement has the effect of suppressing claims for loss amounting to less than the additional premium, but the total of such losses prior to making claim may run into an amount considerably larger. Under the 80 per cent coverage, the insurer pays "not exceeding 80 per cent of the first $250 and 100 per cent of the amount in excess of $250" of each loss. For further discussion of these provisions, see C. A. Kulp, "Casualty Insurance," pp. 194–196.

The insurer also agrees, in addition to the applicable limit of liability

> to pay general average and salvage charges for which the insured becomes legally liable, as to the automobile being transported.

The reference to general average and salvage illustrates the close relationship between this insurance and marine insurance. This same agreement applies to the transportation insurance provided under the comprehensive cover.

2 Theft. Covers loss "caused by theft or larceny."
The insurer will, in addition, reimburse the named insured for expenses incurred to rent a substitute automobile during the period commencing 48 hours after the theft has been reported to the insurer and the police and terminating when the stolen automobile is returned to use or the insurer pays the loss. However, this reimbursement is limited to $10 for any one day and $300 in the aggregate.

3 Combined Additional Coverage. Covers loss caused by (a) windstorm, hail, earthquake, or explosion, (b) riot or civil commotion, (c) aircraft damage, (d) vandalism (subject to a $25 deductible), (e) flood or rising waters, or (f) external discharge or leakage of water.

4 Towing and Labor Costs. Covers

> towing and labor costs necessitated by the disablement of the . . . automobile, provided the labor is performed at the place of disablement.

By combining the insurance under 1, 2, and 3, above, the insured approximates the coverage of comprehensive insurance, but he is covered only against loss due to the enumerated causes, while comprehensive insurance covers all loss except from causes definitely excluded.

Definitions. Certain words used in the contract provisions affording physical damage insurance have meanings unique to those provisions, as follows:

"insured" means

(a) with respect to an owned automobile,
  (1) the named insured, and
  (2) any person or organization (other than a person or organization employed or otherwise engaged in the automobile business or as a carrier or other bailee for hire) maintaining, using or having custody of said automobile with the permission of the named insured and within the scope of such permission;

(b) with respect to a nonowned automobile, the named insured and any relative while using such automobile, provided his actual

operation or (if he is not operating) the other actual use thereof is with the permission, or reasonably believed to be with the permission, of the owner and is within the scope of such permission;

"non-owned automobile" means a private passenger automobile or trailer not owned by or furnished for the regular use of either the named insured or any relative, other than a temporary substitute automobile, while said automobile or trailer is in the possession or custody of the insured or is being operated by him;
"loss" means direct and accidental loss of or damage to (a) the automobile, including its equipment, or (b) other insured property;
"collision" means collision of an automobile covered by this policy with another object or with a vehicle to which it is attached or by upset of such automobile;
"trailer" means a trailer designed for use with a private passenger automobile, if not being used for business or commercial purposes with other than a private passenger, farm or utility automobile, and if not a home, office, store, display or passenger trailer.

Two or More Automobiles. If two or more automobiles are insured under one contract the terms of the contract apply separately to each, a motor vehicle and a trailer or trailers attached to it being regarded as separate automobiles under covers 1 to 4.

Amounts of Insurance. Collision insurance is written with a limit of the *actual cash value* of the automobile. Other insurance covering loss to the automobile may be written for an expressed amount as a limit, or with the actual-cash-value limit. The latter is usual. The limit for any loss to any trailer not owned by the named insured is $500. Payment of towing and labor costs is limited to an agreed amount, commonly $25, for each disablement.

Other Insurance. If there is other insurance covering a loss, the usual provision for pro-rata liability is applicable; but insurance covering a temporary substitute, but nonowned, automobile is excess over other insurance.

MAJOR FEATURES OF OTHER CONTRACTS

The family automobile policy (FAP) is by no means the only automobile insurance contract, but in this introductory treatment of the subject there is only enough space to present a brief description of some other major contracts.

Special-package Automobile Policy

The *special-package automobile policy* (SPAP) is an economy version of the family automobile policy. It was conceived in response to price competition from independent insurers, but it contains several features that can be justified on other grounds, such as avoidance of duplication of benefits. The principal features that distinguish the SPAP from the FAP are the following:

1 The insured has less choice with respect to the covers to be included in the package and the policy limits. For example, the liability insurance must include liability insurance, medical payments, accidental-death benefits for the named insured or spouse, and uninsured-motorists protection. The insured may select his own liability-insurance and medical-payments-insurance limits, but the insurer limits accidental-death benefits to $1,000 per person and the uninsured-motorists coverage to $20,000 per occurrence.
2 The liability insurance is subject to a single limit per occurrence.
3 Resident relatives who own a private passenger automobile are not covered under the policy when they drive nonowned cars. It is assumed that they will obtain such protection from insurance on their own cars.
4 Numerous provisions are included to prevent duplication of benefits. For example, a claimant receiving medical-payments benefits must agree in writing that these benefits will reduce the amount of any liability settlement. The medical payments insurance is excess insurance over most other forms of medical expense insurance. Finally, the insurer has subrogation rights with respect to these payments.

Basic Automobile Policy

Persons not eligible for the FAP or the SPAP must purchase the *basic automobile policy* (BAP). Partnerships and corporations, therefore, use this policy no matter what type of automobile they insure. Individuals and families insuring some vehicle other than a private passenger car must use this form, as well as individuals who insure a private passenger car under an assigned-risk plan (described in Chapter 30).

Until the FAP and the SPAP were developed, this policy was issued to all insureds. Because it was designed to cover all types of persons insuring all sorts of automobiles, this contract is long and complex. The BAP provides basically the same protection as the FAP, but it is less liberal in several respects. For example:

1 The injuries or damage for which the insured has liability protection must be caused by an "accident," not an occurrence.

2 Except for individuals insuring a private passenger car under this policy under an assigned-risk plan, there is no protection with respect to the use of nonowned automobiles.
3 The liability protection for the use of trailers and the coverage for damage to trailers are more limited.

Comprehensive-automobile-liability Policy

Businesses or individuals purchasing the BAP face a major gap in their coverage because of the lack of protection with respect to nonowned cars, such as hired cars, borrowed cars, or employee cars used in the business of the insured. One way to fill this gap with respect to the liability exposures is to purchase a *comprehensive-automobile-liability policy* which covers occurrences arising out of the ownership, maintenance, or use of *any* automobile not excluded. This insurance is written by attaching a coverage part to the basic policy or jacket described in Chapter 17. If written in conjunction with comprehensive general liability insurance, the result is a rather broad liability-insurance contract.

An alternative approach would be to purchase a *schedule-liability-insurance policy*. Under this policy the insured can choose to include one or more of the following sources of liability: (1) owned automobiles, (2) hired (and borrowed) automobiles, and (3) other nonowned automobiles. This third division is designed primarily to protect employers against their liability for the use by employees of their own private passenger cars on company business. The comprehensive-automobile-liability-insurance contract provides at least as much protection.

Garage Liability Insurance

Designed for automobile dealers, repair shops, service stations, and the like, *garage liability insurance* combines automobile liability insurance with general liability insurance. This protection can be written through a coverage part attached to the basic policy described in Chapter 16. The general liability insurance covers the premises-operations hazard and the completed operations-products hazard. The automobile liability insurance may be limited to automobiles not owned or hired, or it may cover all automobiles—owned, hired, customers', and others not specifically excluded.

Elevator liability insurance and *garagekeepers' legal liability insurance* can also be included. The latter cover protects the insured against his liability for damage to automobiles in his care, custody, or control if this damage is caused by certain specified perils.

Special Physical Damage Insurance for Automobile Dealers

Because automobile dealers have some unique exposures, some special physical-damage-insurance policies have been designed for them. One contract permits the dealer to purchase insurance against certain perils on new and used cars consigned to, or owned by, him. Fire and the extended-coverage perils are much more important threats to the dealer than to other automobile owners because of the stationary nature of much of the exposure.

When a customer buys insurance on the installment plan, he is usually required to purchase physical-damage insurance, including a loss-payable clause that protects the dealer in the same way that the standard mortgagee clause in the fire-insurance contract protects the mortgagee. Sometimes, however, the dealer protects himself against failure of the purchaser to buy insurance through single interest insurance that covers only his own interest.

QUESTIONS

1 An insured under a 1-year automobile-liability-insurance contract that took effect on Apr. 1, 1969, has an accident on Oct. 4, 1969 as a result of which a claim for damages for bodily injury is made against him. He promptly reports the accident and the claim to the insurer. In the course of its investigation, the insurer learns that the car has been garaged in Chicago during the period since April 1, though the insured stated that it would be garaged in a country town where he has a summer residence and where the insurance rate is much lower than in Chicago. What are the obligations of the insurer under the contract?

2 Jones, insured under an automobile-liability-insurance contract, gives explicit permission to Peterson to use his car to drive to Lakeville and return, it being agreed that the car will be garaged at a specified location while Peterson is in Lakeville. Peterson meets an attractive girl and takes her for a drive after arriving at Lakeville, during which he runs into a pedestrian who makes a claim for damages for bodily injury, naming both Jones and Peterson as defendants. What are the obligations of the insurer?

3 An insured, as a result of an accident, is required by the state, as a condition of continuance of his car registration, to furnish evidence of financial responsibility to pay damages that may be incurred as a result of further accidents. The insured produces his automobile-liability-insurance contract, which is accepted as such evidence. Later, he has an accident during the term of the contract and a claim for damages is made against him. Both accident and claim are duly reported to the insurer, but the insured refuses to assist in the investigation of the accident or to appear in court

as a witness in the suit that is brought against him. The injured person recovers a judgment of $3,000. What are the obligations of the insurer? Of the insured?

4 An insured under an automobile-insurance contract has purchased the comprehensive cover, but no collision insurance. His car leaves the road, runs into a telephone pole, and is damaged by the impact to the extent of $150. As a result of the accident the gasoline is ignited and the car is destroyed. How much may the insured collect?

5 An insured owns and insures two automobiles, a Buick and a Ford. He insures the Buick with the Chicago Insurance Company, and the Ford with the San Francisco Insurance Company, under contracts providing all available covers. He purchases an additional car, a Chrysler, but does not notify either insurer. Fifteen days after the purchase, and within the terms of both contracts, he is involved in an accident while driving the Chrysler, and a claim is made against him. He notifies the insurers of both accident and claim. What are their obligations? Had he traded the Buick for the Chrysler, what would their obligations have been? In each case what are the obligations of the insured?

6 Smith has a family automobile policy with $25,000/$50,000 and $10,000 liability limits and medical payments of $1,000 per person. As a result of his negligent operation of his automobile, he is involved in an accident causing injuries to himself and to a guest in his automobile. Smith incurs $800 in medical expenses and loses $400 in wages. The guest has a claim for $20,000, of which $4,000 represents medical expenses. How much will the insurer pay to each person?

7 How would you answer question 6 if the policy were a special-package automobile policy? A basic automobile policy?

8 Contrast the protection afforded with respect to the operation of nonowned cars under the various automobile-insurance contracts.

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MULTIPLE-LINE-INSURANCE CONTRACTS

Until the late 1940's property and liability insurance were compartmentalized by law and by custom as fire insurance, marine insurance, or casualty insurance. Fire insurance included fire insurance, windstorm insurance, explosion insurance, automobile comprehensive insurance, and several other forms of specified-perils covers. Marine insurance was defined according to the Nationwide Definition described in Chapter 14. Casualty insurance included primarily health insurance, general liability insurance, workmen's compensation insurance, automobile liability insurance, glass insurance, and theft insurance. In most states fire insurers could write only fire insurance and, if they met certain additional requirements, marine insurance, but they could not write casualty insurance. Casualty insurers could write only casualty insurance.[1] No new types of insurance could be added to fire insurance or casualty insurance without changing the state statutes. As a result no single insurer could issue a contract covering both fire and theft losses to the inventory of a department store or an all-risks contract on a dwelling.

The reasoning in favor of compartmentalization was that insurers were more likely to remain solvent and render adequate service if they specialized and if their entry into new lines was carefully regulated. Most insurers did not originally challenge this reasoning. As the insurance business developed experience and improved its financial condition and as the demand for broader covers increased, compartmentalization faced increasing challenges. One way to circumvent the laws was to form a group or fleet of insurers. For example, the group might include a fire-and-marine insurer that owned a casualty insurer. Together the insurers in the group could write all types of nonlife insurance specified in the statutes. A contract could be issued combining fire and casualty perils, but the promises with respect to the fire perils had to be

[1] Only life insurers could write life insurance. This restriction still applies in most states.

made by the fire insurer and the promises with respect to the casualty perils by the casualty insurer. Marine insurers were able to circumvent compartmentalization for a while because marine insurance was undefined, but this ended with the adoption of the Nation-wide Definition in 1933. By the late 1940's, however, most states had enacted "multiple-line" legislation that permitted one insurer to write all types of property and liability insurance plus health insurance. Insurers were also permitted to write any new lines of insurance for which they could secure approval from state regulatory authorities. By 1955 all states had enacted such legislation and the stage was set for some important product developments.

This chapter deals with some important contracts that were made possible by this multiple-line legislation. In 1967 multiple-line contracts accounted for 12 per cent of the property and liability insurance written, and the proportion is expected to increase. Families in particular have switched from the traditional contracts to the homeowners program, described on pp. 276–280.

Some observers, however, believe that progress should have been even more rapid. Barriers to more rapid use of the multiple-line concept include a human reluctance to change the established way of doing things, financial requirements, a personnel structure based on the demands of compartmentalization, the unknown hazards associated with new covers, rigid government contract and rate regulation, and many other factors.

BASIC FEATURES

Multiple-line-insurance contracts, the newest development in property and liability insurance, share several features with the first form of modern insurance, ocean marine insurance. These are (1) broad coverage with respect to perils, (2) a requirement that the amount of insurance be equal, or close, to the value exposed to loss, and (3) liberal use of franchises and deductibles.

Multiple-line-insurance contracts are attractive because of their relative simplicity, breadth of coverage, and convenience. They can also be sold at attractive premium rates for several reasons. First, the expenses involved in selling and servicing one contract are less than if several contracts had to be used to provide the same coverage. Second, insureds are more carefully selected and, particularly with respect to some included perils such as theft, some insureds will buy protection under a broad multiple-line contract who would not buy a contract covering only those perils because they estimate their chance of loss to be too low. Third, forcing people to buy large amounts of insurance relative to value reduces the rate required per unit of insurance. The reasoning here is that underlying the coinsurance principle described on pp. 146–149. Fourth, deductibles exclude the frequent small losses.

BUSINESS CONTRACTS

Business multiple-line contracts include a wide variety of forms. The first developments included several property-insurance contracts, such as the commercial-property form, the manufacturers-output policy, the industrial-property policy, the office-and-contents form, and the public-and-institutional-property form. This development will be illustrated by the first two of these contracts. A more recent development, following the success of the homeowners program, combines property and liability insurance in one contract.

Commercial-property Form

The commercial-property form, which is attached to the statutory fire policy, provides protection for most retailers and wholesalers that closely resembles the jewelers' block policy. In fact, it was originally called a mercantile block policy.

The form covers direct losses caused by all risks not specifically excluded. War, infidelity of employees, flood, and earthquake are among the excluded perils. The insured property includes the insured's stock of goods, wares, and merchandise and, if he desires, his furniture, fixtures, and equipment. Property of others, such as customers or dealers, is also covered. The loss can occur anywhere within the continental United States excluding Alaska or if the property is in transit in Canada. Separate policy limits apply to losses at various locations. The form can be written on a nonreporting basis with an 80, 90, or 100 per cent coinsurance clause or on a reporting basis. A $50 deductible applies to losses, except those caused by certain specified common perils.

Manufacturers-output Policy

Manufacturers can purchase all-risks protection on their personal property (but not money, securities, and other excluded property[2]) under a manufacturers-output policy. The policy does not cover property on the insured's manufacturing premises unless there is an endorsement covering this location. Such endorsements are now in common use. The form is always written on a reporting basis and runs continuously until canceled. Although no deductible clause is mandatory, most insurers encourage a minimum deductible of $50. The maximum deductible is $5,000. A minimum premium of $5,000 reduces the popularity of this cover.

[2] Vehicles licensed for highway use are covered except with respect to loss by collision or overturn.

Special Multi-peril Program

The special multi-peril program makes available in a single contract broad protection against property and liability losses. This package program is the business counterpart of the homeowners program described below. The first contract in this program was designed in 1960 for motels, but most types of business are now eligible for this program. At first insurers were reluctant to combine liability insurance with property insurance because insureds who are high-quality property insureds are sometimes low-quality liability insureds. Competition, however, has forced more and more insurers to enter this field.

Although there are some special rules and forms that depend upon the nature of the business insured, most businesses insured under this program receive the same mandatory coverage, can select the same optional coverages, and have their rates determined by the same procedure. A basic policy or jacket contains the declarations, the provisions of the statutory fire policy, and some general conditions. The declarations section indicates what coverage the insured has selected under each of the four sections of the contract: property coverage, liability coverage, crime coverage, and boiler-and-machinery coverage. The forms and endorsements that complete the contract depend upon the coverages selected by the insured.

The insured must select some property coverage under Section I. The basic-property form protects the insured against direct losses to his buildings or to his personal property caused by fire, lightning, or any of the extended-coverage perils. The form includes some limited protection against losses off the premises, extra expenses incurred in continuing operations following a direct loss, and replacement costs that exceed the actual cash value of the direct damage. Coinsurance provisions and two loss-deductible clauses patterned after those explained on pp. 278–279 are also a feature of this form. Many optional forms and endorsements are available. For example, buildings and personal property can be insured against additional specified perils or on an all-risks basis,[3] consequential losses such as business interruption can be included, and the contract can be written on a reporting basis.

The insured must also purchase some liability coverage under Section II. The basic form covers occurrences arising out of the ownership, maintenance, or use of the described premises and necessary or incidental operations. Included are losses arising out of products or completed operations, but this coverage can be eliminated, as can the medical payments insurance included in the basic form. Several optional endorsements are available, the most important of which convert the coverage to comprehensive general liability

[3] The all-risks coverage on personal property is basically the commercial-property form described earlier in this chapter.

insurance or extend it to include personal injury liability insurance or employee nonownership automobile liability insurance.

The other two sections are optional. Under Section III the insured may choose the equivalent of the comprehensive destruction, disappearance, and dishonesty policy discussed in the next chapter.[4] Under Section IV he may purchase boiler and machinery insurance, which is also explained in the next chapter.

Independent Contracts. The contracts described above are those used by bureau insurers, but many insurers have chosen to develop their own brands. Some have included automobile liability insurance and automobile physical damage insurance in their packages.

The Future. The future business package may include the ingredients of the special multi-peril contracts, automobile insurance, and workmen's compensation insurance with endorsements available to fill any gaps that remain.

THE HOMEOWNERS PROGRAM

Like the special multi-peril-program contracts, which were patterned after the homeowners program, a homeowners contract consists of (1) the basic contract, (2) a form with two sections—Section I for property insurance and Section II for liability insurance, and (3) such detailed endorsements, if any, as the insurer and the insured may agree upon. These contracts are, for the most part, packages of existing contracts such as the dwelling-and-contents form with extended-coverage and vandalism endorsements, the dwelling-and-contents broad form, the dwelling-building special form, theft insurance, the personal property floater, and comprehensive personal liability insurance.

Divisions in Contract

The three divisions of a homeowners contract are explained briefly below.

Basic Contract. The basic contract contains the declarations indicating the named insured, types of coverage, limits of liability, premium makeup, descrip-

[4] Some insurance against theft losses can be purchased under Section I, but Section III includes a fidelity bond and all-risks coverage on money and securities.

tion of the exposure, and specification of which of certain variable provisions are applicable. The declarations are followed by the 1943 standard fire-insurance contract, by a war-risk-exclusion clause defining war risks and the applicability of the clause to different parts of the contract, general conditions applicable to Sections I and II of the forms in varying degree, conditions applicable only to Section I, and conditions applicable only to Section II.[5]

The contract is complicated, first, by the necessity, under state regulation, of including the standard fire-insurance contract, much of which is modified or waived, and second, by the vast variety of exclusions and conditions applicable to the two sections and to the long lists of types of property, perils, and losses covered.

Forms. There are five forms, each consisting of Sections I and II. Section I varies from form to form, as explained below; Section II is the same for all risks. The principal variations are in breadth of coverage. The five forms carry the following titles: (1) Basic Form, (2) Broad Form, (3) Special Form, (4) Contents—Broad Form, and (5) Comprehensive Form. The most popular form is Form 2, followed by a closely related contract, Form 3. Owner-occupants of a dwelling used exclusively for private residential purposes and containing no more than two families are eligible for any one of the five forms. Other homeowners and tenants are eligible only for Form 4.

Endorsements. The endorsements serve the usual purposes, such as amending the contract after it has come into force, adjusting it to special situations, and narrowing or broadening it to suit the insured's desires.

The Forms

While the structure of the contract, for purposes of arriving at an insurance agreement, puts the basic document first, the heart of the contract is the form. Form 2, the most popular contract, will be studied first and in the most detail.

Form 2. Section I of Form 2 provides property insurance on a package basis against the perils covered in the dwelling-and-contents broad form plus theft. The insured selects the amount of insurance on the dwelling but the minimum

[5] In the remainder of this chapter attention will be directed to, and explanation will be given of, certain provisions peculiar to the homeowners contract, but complete understanding can be attained only by careful study of the contract itself.

amount of insurance to be placed on each of the other property-insurance items is fixed as a percentage of the dwelling insurance as follows:

Appertaining private structures . .	10%
Unscheduled personal property:	
On premises	50%
Away from premises	10% of the on-premises amount but not less than $1,000
Additional living expense	20%

For example, if the insured purchases $25,000 insurance on the dwelling, he also receives $2,500 on appertaining private structures, $12,500 on personal property on the premises, $1,250 on personal property away from the premises, and $5,000 on additional living expense. The insured is encouraged to select a reasonable amount of protection on the dwelling relative to its value because of the replacement-cost feature of the dwelling-and-contents broad form described on p. 169. Because the insurance on the personal property is related to the insurance on the dwelling, the insured tends to purchase more personal property insurance under this program than under the more traditional contracts.

The property covered is indicated by the items listed above. Automobiles and animals are not included under personal property, but money is covered up to $100, accounts, bills, deeds, securities, and the like up to $500, manuscripts up to $1,000, jewelry and fur items with no special limitation except a $500-per-item limit for theft losses, and watercraft up to $500. Loss to trees, shrubs, and plants is covered up to 5 per cent of the amount of dwelling coverage, except loss caused by windstorm, hail, or vehicles owned or operated by an occupant of the premises.

The persons insured include the named insured and, if they are residents of his household, his spouse, the relatives of either, and any other person under 21 in the care of an insured. Personal property is covered if it is owned, worn, or used by an insured or, at the option of the named insured, owned by others on the insured's premises or in temporary residence.

The protection away from the premises extends to anywhere in the world.

The contract may be written only for a term of 3 years but the premium can be paid in annual or more frequent installments.

The insured can reduce his premium if he selects one or more of the four optional deductible clauses. Under clause 1 the deductible applies only to windstorm or hail damage to the buildings or to personal property in the open. It does not apply to additional living expenses. No losses of $50 or less are

covered, but if the loss exceeds $50, the insurer pays 111 per cent of the excess up to the amount of the loss. Therefore, on losses of $500 or more there is no deductible. Clause 2 applies the same deduction to losses not caused by fire or lightning or included under clause 1. A modified clause 2 limits the deductible to certain specified perils. A fourth option is a flat (nondisappearing) $100, $250, or $500 deductible applicable to all perils.

Section II of this form provides the equivalent of comprehensive personal liability insurance, described on pp. 243–244. The minimum liability limit is $25,000 per occurrence and the minimum medical-payments limit $250 per person and $25,000 per accident. The coverage for property damage to the property of others is $250 per accident.

Form 1. Form 1 differs from Form 2 in two principal respects. First, the property-insurance perils are fire, lightning, the extended-coverage perils, vandalism, and theft. Second, the minimum additional-living-expense insurance is 10 per cent of the dwelling insurance.

Form 3. Form 3 provides the insurance with essentially the same protection as Form 2, except that the insurance on the dwelling is all-risks.

Form 4. Form 4 is the tenants' Form 2. There is no insurance on the dwelling or appertaining private structures, but the other items are the same. The tenant selects the amount of insurance on personal property on the premises, subject to a minimum requirement of $4,000. Off-premises losses are covered up to 10 per cent of this amount and additional living expense up to 20 per cent. The insured may, at his option, apply up to 10 per cent of the insurance on the premises to improvements and betterments he may have made to the real estate.

Form 5. Form 5, the most liberal form, differs from Form 2 in two principal ways. First, the property insurance is all-risks with respect to both the dwelling and the personal property. Second, the policy limits are different. The minimum amount of insurance permitted on the dwelling is $15,000. Personal property, whether on or away from the premises, must be insured for at least half the amount on the dwelling. Under the deductible clauses, if the loss exceeds $100, the insurer pays 125 per cent of the excess up to the amount of the loss.

Independent Forms. Many insurers have chosen to develop their own homeowners program instead of the bureau program described above. Some have included automobile physical damage insurance and automobile liability insurance as part of their program. Life insurance and health insurance are also sometimes included as part of the package.

QUESTIONS

1 In what respects do multiple-line property-insurance contracts resemble ocean marine insurance?
2 Why have multiple-line contracts been invented so recently?
3 Compare the commercial-property form with the jewelers' block policy.
4 The Smith Department Store may purchase a special multi-peril policy. Why is it probably interested in such a policy? What options does it have under this policy?
5 Outline the differences between the five homeowners forms.
6 Explain and contrast Sections I and II of the homeowners forms.
7 As an owner-occupant of a dwelling house arranging for insurance, which of the homeowners forms would you choose?
8 Explain the purpose of the homeowners "deductible" clauses. Would you eliminate them or accept them as they appear in the regular forms? Would you prefer higher amounts?

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MISCELLANEOUS PROPERTY-INSURANCE CONTRACTS

The principal types of property-insurance contract have been discussed in preceding chapters. There are numerous other types that are of less general interest, though in individual cases they may be, and often are, quite as important to the insured. Many of them, in their general provisions, follow the fire-insurance contract, differing from it principally in the perils against which insurance is written. This fact facilitates coverage under the extended-coverage endorsement, the dwelling-and-contents broad form, or the newer multiple-line contracts. Others, while including provisions common to most insurance contracts, have a high degree of individuality.

No attempt will be made here to deal with all available contracts other than those already discussed or to discuss exhaustively any one type. The purpose of this chapter will rather be to draw attention to those covers that are of outstanding interest because of their usefulness in their particular fields and to point out certain peculiarities of coverage.

Any contingency that *may* cause financial loss is a conceivable basis for insurance, and the failure of insurers to offer coverage should not deter one from seeking it.

Coverage of the same property (or different sorts of liability in respect to the same property or situation) under more than one contract entails the possibility of disagreement as to which contract covers a particular loss—if the contracts are with different insurers, the disagreement may be of serious import to the insured. It is generally desirable to place with the same insurer all insurance where such disagreement might arise.

Burglary, Robbery, and Theft Insurance

Loss of property by theft or robbery is a hazard to which all owners of movables are subject. Loss through piracy and other acts of sea marauders has always been covered under the marine-insurance contract which has gone even

further and protected against barratry of master or crew. But until comparatively recently, it has not been possible to secure insurance protection against loss of property by theft from its normal location. The idea of such insurance was suggested as early as 1787 by one William Weller, who applied for a royal charter for a company. But though crimes of the kind were prevalent enough, the time was not ripe, and nothing came of the scheme. There were sporadic attempts to cover such risks during the next century, but there was no considerable business written before about 1890. Even as late as 1900, the total volume of premiums was only about $500,000. This branch of insurance was regarded by insurers and their representatives as a mere side line. The business has grown until it is now regarded as one of the basic forms of insurance.

Meaning of Terms. Since the risks insured against by contracts in this field of insurance arise out of actions that are criminal in nature, it might be expected that the risk covered would be described in the language of statutory and common law. But the term *theft* is not in many states a statutory term; the corresponding statutory term is *larceny*, which has been said to cover a multitude of sins. The terms *burglary* and *robbery* are statutory terms, but their definitions differ somewhat in different jurisdictions. It is desirable that a term used to describe the coverage under an insurance contract conform to popular use and understanding, and that its meaning be not limited to particular jurisdictions. The terms have been defined in insurance contracts with this end in mind. This practice has given rise to the legal question whether a definition not following the statute can properly be set up by contract, and its observance required by the contract. The question was raised before the highest court of New York State, which held that it was permissible if the contract provision contravened no principle of public policy and was not ambiguous.[1]

Standard policy forms are not required by statute as in fire insurance, but insurers, through associations, have voluntarily largely standardized the forms in use.

In the standard mercantile form, burglary is defined as

> felonious abstraction of insured property (1) from within the premises by a person making felonious entry therein by actual force and violence as evidenced by visible marks made by tools, explosives, electricity or chemicals upon, or physical damage to, the exterior of the premises at the place of such entry, or (2) from within a showcase or show window

[1] *Rosenthal et al. v. The American Bonding Company,* 100 N.E. 716 (1912).

> outside the premises by a person making felonious entry into such showcase or show window by actual force and violence, of which force and violence there are visible marks thereon.

Robbery is defined in one contract[2] as

> taking of insured property (1) by violence inflicted upon a messenger or a custodian; (2) by putting him in fear of violence; (3) by any other overt felonious act committed in his presence and of which he was actually cognizant, provided such other act is not committed by an officer, partner or employee of the insured; (4) from the person or direct care and custody of a messenger or custodian who has been killed or rendered unconscious; or (5) under Coverage A, [loss inside the premises] (a) from within the premises by means of compelling a messenger or custodian by violence or threat of violence while outside the premises to admit a person into the premises or to furnish him with means of ingress into the premises, or (b) from a showcase or show window within the premises while regularly open for business, by a person who has broken the glass thereof from outside the premises.

Other definitions are also based on the fundamental association of robbery with violence.

The terms "theft" and "larceny" are, for all practical purposes, synonymous. They are not specifically defined, because it is intended that the contracts in which they are used shall indemnify against every form of stealing.[3] Theft policies, therefore, are much more liberal than burglary or robbery policies, other things being equal.

Burglary, robbery, and theft contracts cover damage to property by burglars, robbers, or other thieves as well as loss by the taking of property.

Contract Forms. There is a wide variety of contract forms and combinations of forms designed to meet the needs of different insureds and situations. These forms are subject, in turn, to variation by endorsement. At one extreme they include limited contracts such as the mercantile open-stock burglary policy, which covers only (1) burglary losses of (2) merchandise, furniture, and fixtures. At the other extreme they include such contracts as the comprehensive destruction, disappearance, and dishonest policy. This policy permits the insured to select one or more of the following coverages, each of which is subject to its own limit of liability:

[2] The *Money and Securities Broad Form.*
[3] In many contracts theft is now defined as "any act of stealing."

1 Employee-dishonesty coverage through either a commercial blanket bond or a blanket position bond. This coverage is explained in the next section of this chapter.
2 Money-and-securities broad form—on premises. This form provides all-risks (not just theft) insurance on money and securities and robbery and safe burglary insurance on other property.
3 Money-and-securities broad form—off premises.
4 Protection against the acceptance in good faith of illegal or counterfeit money orders or paper currency in exchange for merchandise, services, or money.
5 Depositors' forgery coverage which protects the insured against forgery losses on checks and similar written promises, where the insured made the promise or is supposed to have made the promise.

This contract can be endorsed to include such extras as mercantile open-stock burglary (sometimes theft) insurance and forgery insurance on incoming instruments.[4]

Fidelity Bonds and Surety Bonds

The business of suretyship is usually subdivided into two categories: fidelity bonding and surety bonding. In a broad sense, bonds issued in either category are surety bonds, that is, they are written instruments whereby either by direct statement or by clear implication one party becomes surety for another. They all provide indemnity to a third party, the obligee (or the insured, if the contract is in form an insurance policy), for loss caused by the principal (sometimes called the "obligor") under the bond or by the person covered under the policy. But always he is primarily responsible for his act and must make good if he can. There is a fidelity (dishonesty) element in the risk assumed under all bonds. But in the class of bonds known as *fidelity bonds* that is the only risk. In a large proportion of the bonds classed as *surety bonds* the surety assumes also risks of incapacity, technical or financial or both. One recent writer puts the distinction in the following terms:[5]

> All corporate surety bonds are, broadly speaking, divisible into two major classes: fidelity bonds and surety bonds. Fidelity bonds are usually given in security of an implied obligation [honesty], while surety bonds . . . are given in security of an expressed obligation, the terms and conditions of which are usually evidenced by some instrument in writing.

[4] This contract was inspired by the several forms of bankers' blanket bond which were developed in conjunction with the American Bankers Association.
[5] G. W. Crist, Jr., "Corporate Suretyship," p. 22.

The implied obligation secured by the usual fidelity bond is, of course, the obligation to deal honestly with one's employer. Efficiency or performance of the principal is not guaranteed by a fidelity bond; so long as he is faithful to his trust, he may do a poor job, involve his employer in financial difficulties, or be otherwise unacceptable as an employee without involving the surety. It is only when the employer suffers loss through his dishonesty that the surety becomes responsible.

Under the surety bond the surety guarantees performance and becomes responsible for failure to perform. For example, the surety may guarantee that a contractor will construct a house in accordance with the terms of a specified contract. If he fails to meet those terms, the surety is responsible for paying to the obligee any loss resulting from the failure or to carry out the contract itself. It matters not whether the failure is due to dishonesty, incompetence, or just bad luck.

Fidelity bonds may, in some cases, be extended to insure faithful performance of the principal's duties to his employer, thus adding an element of surety-bond coverage.

Surety-bond Forms and Classes. It is in the second category of bonds that the great variety of forms is found. For most bonds the surety has printed forms, but not infrequently cases arise where the entire bond must be prepared by typewriter. Generally these forms are adaptations of the basic form quoted on pp. 100–101. The major differences are in the language following the word "Whereas" in the seventh line of that form, language that sets forth the express terms of the principal's obligation, in security of which the bond is given, either in full or by reference to attached documents, and in the language following the words "if the said . . . shall" in the ninth line, which sets forth the violations of that obligation which will invoke the penalty of the bond.

The principal classes of surety bonds are:

1 *Contract bonds*, securing the performance of contracts of all kinds, for construction of huge public works like Boulder Dam or the San Francisco-Oakland Bay Bridge, for construction of small private dwellings, for supply of materials, for transportation, and a multitude of other purposes.
2 *Court bonds*, required of litigants who desire to take certain actions affecting the rights of others when their right to do so is questioned or opposed. They fall into two groups:
   a Those required to protect defendants' rights when a writ is sought—attachment, replevin, garnishment, etc.
   b Those required to protect plaintiffs when the defendant seeks to interpose a blocking writ—appeal, release of attachment, release of replevin, release of garnishment, etc.

Underwriters regard the first group as involving only normal credit risks, the second class as more hazardous.

3 *Fiduciary bonds,* issued in behalf of persons in positions of trust under court appointment, such as receivers of insolvent corporations or estates, executors of wills or administrators of estates, guardians of minors or incompetents.

4 *Public-official bonds,* which are principally fidelity bonds, but which are in the usual surety-bond form and sometimes cover losses due more to misjudgment than to dishonesty. For example, a sheriff executing a writ of attachment might through error seize the property of the wrong person. He would be responsible at law for the loss so caused, and the surety shares his responsibility.

5 *License and permit bonds,* which are often required by federal, state, or local law when a person applies for (a) a license to be an electrician, a beauty parlor operator, a private detective, or some other licensed occupation or (b) a permit to engage in certain activities, such as intalling a sign, excavating, or blasting with explosives.

Space is not available for detailed discussion of the forms of these bonds, nor does it seem to be called for. With the exercise of a little imagination the student can guess fairly closely the language that would be appropriate to insert at lines 7 and 9 in the form on page 100 to fit the several types of guaranty, though some of it, e.g., in the bond of the receiver of a railroad, might be lengthy and abound in descriptive details.

Surety bonds do not, like insurance policies, contain any provisions relative to procedure for loss settlement. The practice of suretyship is so ancient that custom, common law, and statutes lay down the procedure for enforcing the penalty of the bond.

Modern Fidelity Bonds. Originally, fidelity bonds also followed the traditional form and were issued individually on separate application of the principal, with verification of facts through an employer's statement. This practice imposed on each employer the custody of the several individual bonds of his employees and the necessity of watching expiration dates for proper renewal. With a large staff this was no small task, and gradually, through the demands of employers and the competition of the surety companies, the practice was changed so that a single master bond was issued to cover all employees who might be bonded, and a schedule attached setting forth, as to each employee, his name, the position in respect of which he was bonded, and the amount for which he was bonded. The traditional form of bond is not adapted to this treatment, and a considerably different form is used. A separate application

is called for from each principal, and his name is admitted to the schedule only if investigation develops no unfavorable features. If a man resigns, or if a new employee is taken on, the surety company must be notified, and the schedule modified accordingly. Such bonds are *schedule bonds* and are still extensively employed.

Although schedule bonds relieve the employer of much inconvenience, if the concern has many branches and considerable change in personnel, there is yet much detail work in reporting to the surety. If the report is not made promptly, the new employee is not covered. Employers desire to be relieved of this annoyance and risk. To meet this situation, again under the force of competition, the companies issue *position bonds* covering whoever may be employed in a particular position until the bonding company gives due notice of its unwillingness to cover him. Although the employer gains in some respects under this type of bond, he loses the service of the surety company in selecting trustworthy people. The surety also has relinquished much of its special advantage. In fact, the bond in this form comes very near to being essentially an insurance contract. But the process has gone even further.

Under a fidelity bond of any of the types mentioned heretofore, the loss must be proved to have been due to the misconduct of some particular employee covered individually or by position under the bond. Often, however, losses due to the lack of fidelity of employees cannot be definitely fixed on particular individuals. Competition has led to the development of *commercial blanket bonds*, under which it is not necessary to identify the guilty employee. If the loss can be traced to any group of employees covered by the bond, it is covered. The bond does not, however, cover loss due to robbery or other acts of strangers, or due to other than dishonest acts of employees within the definition stated. The amount of indemnity may not exceed in the aggregate the amount of the bond. *Blanket position bonds* are also now issued covering the entire staff, with the amount of the bond available on *each* identifiable employee involved in a collusive loss. For example, if the bond amount is $5,000 and there are three employees involved in the loss, the bond covers that loss up to $15,000. This bond limit is the only major difference between the commercial blanket bond and the blanket position bond.

The forms of surety bonds are not standardized by law as in the case of fire insurance, nor are standard provisions required by statute,[6] but by agreement between the companies that are members of The Surety Association of America many of the leading forms have been more or less standardized, and to some extent forms have been drawn by the insured, e.g., by the American Bankers Association. Fidelity bonds now bear more resemblance in their general form

[6] In the case of certain public-official, licensee, and other bonds running to the state, the form is usually prescribed in the law requiring them.

to an insurance policy than to the traditional bond form. They name as parties only the bonding company and the employer, though, in describing the risk, the employees are named. The covered peril is generally any fraudulent or dishonest act of an employee. Some forms cover only larceny and embezzlement. The covered property includes personal property as well as money, and included in personal property is that for which the employer is responsible.

Formerly, fidelity bonds were issued for fixed periods but renewed by the use of renewal receipts. At the present time they are usually continuous instruments running until canceled by either the employer or the insurer. Unless it were otherwise provided in the bond, the liability of the surety might be held cumulative, covering up to its named limit in each period. This is provided against by the following condition:

> The aggregate liability of the Corporation . . . for or on account of any act or acts of the Employed, shall not exceed the amount for which the Employed shall have been specifically guaranteed at the time such act or acts shall have been committed.

Embezzlement and like crimes are seldom immediately discovered. Clearly the bond should cover misdeeds during its term, whether discovered within that time or not. But liability is generally limited to losses discovered within some period such as 15 months after termination of the bond, not the date of the loss. If the bond is a blanket bond, it may cover a loss incurred many years ago but just discovered even if the guilty employee terminated his employment several years ago.

The surety is not liable for a defalcation, the proceeds of which have been used to pay a preexisting debt to the employer; nor is it liable for any default occurring after notice to it of any act that would constitute a claim; and, finally, condonation by the employer of a fraud releases all liability from and after that time. An employer continues a defaulter in his service at his peril; the surety companies do not feel that they should cover a risk deliberately assumed by the employer.

After having given notice of discovery of any act likely to produce a loss (known in company offices as a "trouble notice"), the employer must, within a specified time, file an affirmative proof of loss under oath, must give the surety all evidence possessed by him, and must give all possible assistance (other than pecuniary) in bringing to justice, prosecuting, and convicting the defaulter, and in procuring reimbursement. If reimbursement were procured, it was formerly usually provided that it would be shared by the employer and surety in the proportion of the losses sustained by each. For example, if a person bonded for $10,000 embezzled $15,000, the surety would be called upon to pay $10,000 and the employer would sustain a loss of $5,000 for

which he would not be indemnified. If the surety company later recovered from assets of the defaulter $6,000, under the terms of the bond it would retain $4,000 and pay the employer $2,000, leaving a net loss to the surety of $6,000 and to the employer of $3,000. This clause, of course, applies only in case the bond is not large enough to reimburse the employer in full, which unfortunately often happens. If the employer is fully indemnified, the surety alone is entitled to the recovery, being subrogated to the employer's claim. Under conditions of severe competition the usual practice is to give the employer all the salvage, less the cost of collecting, until he is fully reimbursed. The wisdom and equity of this are doubtful.[7]

A fidelity bond normally covers dishonest acts committed by employees only during the term of the bond, but it may be written also to cover acts *discovered* during the term regardless of the time of the loss. If a bond supersedes another bond, whether written by the same or a different surety, the succeeding bond, subject to its terms, regularly affords coverage of loss due to acts committed during the term of the prior bond but not discovered until after the termination of the discovery period of that bond.

Cancellation without prejudice to right of recovery by reason of actions that may have already taken place is permitted on substantially the same terms as under casualty-insurance contracts, but usually notice of cancellation by the surety must be given 30 days in advance.

Boiler and Machinery Insurance

Accidents to boilers, other pressure vessels, piping, or machinery may result in loss because of

1 damage to property
2 liability for damage to property of others
3 liability for bodily injury (including death) of others

The boiler-and-machinery contract affords protection against such losses. Originally the only protection afforded was against loss due to explosion of boilers. Later, insurance against loss due to other types of accident was offered under separate contracts. In accord with the general tendency toward unification and coverage of all similar risks of one insured under a single policy, the present-day boiler-and-machinery contract is basically comprehensive. This necessitates some unique provisions in the contract and extensive use of attached schedules in order to describe the risk.

[7] It is because the employer determines the amount for which he will bond any employee that the authors question the wisdom and equity of allowing the employer the full salvage obtained by the surety's efforts.

The contract affords insurance against loss from an accident to an *object* while it is in use or connected ready for use at the location specified in the schedule attached to, and made a part of, the policy. The objects covered are designated and described in the schedules. They may be such objects as boilers, unfired pressure vessels, auxiliary piping, engines, wheels, shafting, turbine, units, motors, or refrigerating systems. Since machinery is generally set up and interconnected there may be doubt about just what constitutes the particular object covered. Each schedule, therefore, contains a formal definition of the object with specifications and limitations. An example of such a definition is the following taken from a boiler schedule (fired vessels and electric steam generators):

> Definition of Object
>
> "Object" shall mean any complete vessel which is designated and described by Schedule and shall also include
>
> **1** any steel economizer used solely with such vessel,
> **2** any indirect water heater used for hot water supply service which is directly in the water circulating system of such vessel and which does not form a part of a water storage tank, and
> **3** any piping on the premises of the Insured, or between parts of said premises, with valves, fittings, traps and separators thereon, which contains steam or condensate thereof, generated in whole or in part in such vessel, and any feed water piping between such vessel and its feed pump or injector;
>
> but Object shall not include
>
> (a) any part of such vessel or piping which does not contain water or steam;
> (b) any reciprocating or rotating machine;
> (c) any electrical apparatus;
> (d) any piping not on the premises of the Insured, used to supply any premises not owned by, leased by or operated under the control of the Insured; nor
> (e) any other piping, any radiator, convector, coil, vessel or apparatus except as included in 1, 2 and 3 above.

The term "accident" in the insuring clause also requires definition appropriate to the object covered. A standard broad boiler contract has these definitions:

> Definition of Accident
>
> As respects any Object which is designated and described by Schedule for which the word "Broad" is inserted in the column headed "Coverage," "Accident" shall mean a sudden and accidental breakdown of the Object, or a part thereof, which manifests itself at the time of its occur-

rence by physical damage to the Object that necessitates repair or replacement of the Object or part thereof; but Accident shall not mean

1 depletion, deterioration, corrosion, or erosion of material;
2 wear and tear;
3 leakage at any valve, fitting, shaft seal, gland packing, joint or connection;
4 the breakdown of any vacuum tube, gas tube or brush;
5 the breakdown of any structure or foundation supporting the Object or any part thereof; nor
6 the functioning of any safety device or protective device.

Furnace Explosion

As respects any Object which is designated and described by Schedule for which the words "Furnace Explosion" are also inserted in the column headed "Coverage," a sudden and accidental explosion of gas or unconsumed fuel within the furnace of said Object or within the gas passages therefrom to the atmosphere shall be an Accident to said Object, but if the words "Furnace Explosion" are not so inserted, the furnace of the Object and the gas passages therefrom to the atmosphere shall be considered as "outside the Object" and such an explosion shall not constitute an Accident.

For other types of object other definitions are necessary and are given in connection with the corresponding schedules.

The contract sets a limit per accident and defines *one accident* to include "all resultant or concomitant accidents whether to one object or to more than one object or to part of an object" but does not set a further total limit of liability.

The insurer agrees, first, to pay for loss to the property of the insured directly damaged by the accident, with the option left to the insurer to repair or replace, *excluding* loss from fire or the use of means to extinguish fire, or loss from accident caused by fire; loss from a combustion explosion outside the object concomitant with, or following, an accident; loss from delay or interruption of business, manufacturing, or process; loss from lack of power, light, heat, steam, or refrigeration; and loss from any indirect result of an accident. Second, to pay for reasonable extra cost of temporary repair, and of expediting repair, of the damaged property not exceeding the amount of the property loss itself and not exceeding $1,000. Third, if the sum of these two items does not reach the policy limit, to pay such amounts as the insured is obligated to pay by reason of liability for loss on property of others directly damaged by the accident and to defend the insured against claims and suits, but the amount payable under this clause is limited to the excess of the limit per accident over the amount paid under the two previous items. Fourth, to

the extent of the amount remaining after meeting the first three obligations, to pay any amounts for which the insured becomes liable by reason of bodily injuries caused by the accident, and to defend suits, excluding, however, liability under any workmen's compensation law. The insurer also agrees, regardless of the limit per accident, to pay for such immediate surgical relief as shall be rendered at the time of the accident. It agrees, in connection with liability claims, to pay the legal expense incurred by it in defending claims and suits, costs taxed against the insured, interest on judgments, and premiums on attachment or appeal bonds, irrespective of the limit per accident.

The contract covers only the excess of the insured's liability over the amount of any other bodily-injury liability insurance covering the loss.

Boiler and machinery insurance is usually carried with the expectation of regular and expert inspection, a service that the insurer not only provides but insists upon. It is not promised because, if an insurer were unable to make inspections as frequently or regularly as contemplated, and in the interval between inspections a serious accident occurred, the insurer might be subject to liability for damages in addition to its contractual liability, on the theory that its negligence in inspection was the cause of the loss. The contract provides only that the insurer shall be permitted to inspect at all reasonable times during the policy period.

Any representative of the insurer, on the discovery of a dangerous condition, may immediately suspend the insurance by written notice mailed or delivered on the spot. The insurance may be reinstated only by endorsement. The insurer refunds the pro-rata unearned premium for the period of suspension.

In addition to general boiler and machinery insurance, off-premises explosion insurance, residence explosion insurance, outage insurance (affording a fixed payment per hour while an object is out of service), consequential damage insurance, and power interruption insurance are available.

Business interruption due to damage to boilers or machinery may be covered by modification of the basic contract in a manner similar to the modification of the basic fire contract to cover business-interruption losses.[8]

Glass Insurance

Insurance against damage to glass is principally purchased by merchants whose purpose is obtaining quick restoration of display facilities. Consequently, while the contract is written in terms of payment for damage, losses are usually settled by repair or replacement, and insurers compete on the basis of service rather than money indemnity.

The insuring agreement is simple and direct. The insurer agrees

[8] Business interruption insurance is, in this field, still known as use and occupancy insurance and may be written on a valued form.

to pay for damage during the policy period to the glass described in the declarations and to the lettering and ornamentation separately described therein, by breakage of the glass or by chemicals accidentally or maliciously applied.

The insurer further agrees to pay for

(a) repairing or replacing frames immediately encasing and contiguous to such glass when necessary because of such damage;
(b) installing temporary plates in or boarding up openings containing such glass when necessary because of unavoidable delay in repairing or replacing such damaged glass;
(c) removing or replacing any obstructions, other than window displays, when necessary in replacing such damaged glass, lettering or ornamentation.

Exclusions are also simple and direct. The contract does not apply

to loss by fire;
to loss due to war, whether or not declared, invasion, civil war, insurrection, rebellion or revolution, or to any act or condition incident to any of the foregoing;
to loss due to nuclear reaction, nuclear radiation or radioactive contamination or to any act or condition incident to any of the foregoing.

Liability for damage is limited to the actual cash value of the property at the time of loss and to what it would then cost to repair or replace the damaged property with *other of the nearest obtainable kind and quality.* There is a limit of $75 under each of divisions (a), (b), and (c) of the insuring agreement "with respect to loss due to any one occurrence at any one location separately occupied or designed for separate occupancy," but this limit may be increased by endorsement. The insurer reserves the right "to pay for the loss in money" but seldom exercises it. A specific limit may be placed on the liability in respect of any item of glass, lettering, or ornamentation, but in most cases no such limit is placed on the glass items.

Sprinkler Leakage Insurance

Automatic sprinkler systems, designed to prevent or minimize loss by fire, are themselves a hazard. They may cause loss to property by leakage or discharge of water or other substance from the system. Others than the owner or operator may claim damages, alleging liability for loss due to leakage from the sprinkler system. Loss from either cause may be covered under a sprinkler-leakage contract.

This insurance does not cover loss due directly or indirectly to fire, lightning, or various other causes, insurance covering which is available under other forms of contract.

Water Damage Insurance

With some exceptions water-damage-insurance contracts close the gap between the coverage provided by other contracts and complete coverage of damage by water. Like sprinkler-leakage contracts they may be written to cover direct damage or liability for damage. The insured should note particularly the exclusions and the optional endorsements.

Crop-hail Insurance

Crop-hail insurance is written on growing agricultural crops and covers primarily loss from damage by hail. Other perils, the most important of which is fire, are also covered, depending upon the crop and region.

Certain peculiarities of this insurance are the following:

1 Issuance of a policy only on a signed application, which must be signed in duplicate by both the applicant and the agent of the insurer. One copy of the application is attached to the policy contract which is given to the insured.
2 A provision in the application that binds the insurance beginning 24 hours after the application is signed by both the applicant and the insurer's agent.
3 After the application is received, the insurer's option either to issue the policy or decline the business.

Two types of contract are written, the *percentage policy* and the *guaranteed price per bushel policy*. The latter is less common. A loss under this policy is adjusted upon the potential yield of the crop, and is written at an increased rate.

The percentage policy, which is the standard hail contract country-wide, provides for settlement of partial losses on a 100 per cent coinsurance basis. No liability is assumed for damage to buds, blooms, or blossoms of any crop, or for injury to trees or bushes of any fruit or nut crop. Injury to leaves, vines, bushes, or stalks of any crop is paid for only to the extent that the product is affected. No insurance applies until the plants have made a certain minimum growth. If it is possible to replant the acreage and make a crop, liability is limited to the cost of replanting. No abandonment of any crop to the insurer is permitted.

These crop-hail contracts do not have a fixed term, but there is an expiration limit, such as September 15 or November 15, when the crops involved will ordinarily have been harvested.

Farmers can also purchase private insurance to protect themselves against frost and freeze losses to fruit and vegetable crops. Insurance against

drought, excessive moisture, and similar perils to crops is being written on an experimental basis. All-risks crop insurance, similar to that written by the Federal Crop Insurance Corporation, whose operations are discussed in Chapter 38, has been written but is not generally available.

Rain Insurance

Rain may crack cherries, spoil hay, and otherwise do damage to crops, but more often it is beneficial. Rarely, if ever, does rain cause direct property loss. But the consequential damages of an unexpected shower are often large. For example, the calling off of a championship baseball game with rain checks for a subsequent date involves heavy additional expense. Rain insurance was devised to meet such situations.

A number of different forms of rain-insurance policies are written according to the type of venture covered, e.g., public exhibitions covering several days and a number of features, such as a county fair; a department-store special sale for which extensive preparation has been made by advertising; and public entertainments, such as baseball games. The major difference in these forms is in the basis for determining the amount of loss.

Loss under the contract becomes payable if a given amount (usually $\frac{1}{20}$, $\frac{1}{10}$, or $\frac{2}{10}$ inch) of rain falls between the hours, specified in the contract, of a day or days also specified in the contract. The insured is required to arrange for an official reading with a rain gauge at a named point. The insurance covers loss of expected income or expenses incurred or both.

Local agents are not furnished policy forms to be issued and reported on a daily report to the insurer, but must mail an application, signed by the prospective insured, on a form provided, for approval at least a week before the effective date of the contract. Cash for the premium must accompany the application. The contract is not cancellable by either party. If these requirements of cash in advance and no cancellation were not made, insurers might readily be victimized by applicants who prolonged negotiations until almost the time of the event, closing them if the weather appeared threatening but breaking them off if the prospect of rain seemed remote. Retention of the right to cancel by the insurer would certainly arouse the suspicions of the insured as to the good faith of the insurer. Further, the hazard being of a natural phenomenon beyond the control of the insured and the policy being issued by the insurer's office, there is no reason why the insurer should have this right. Since the method of determining the amount of indemnity varies with the nature of the risk, details regarding it cannot be given here without unduly emphasizing a minor type of insurance. It will suffice to say that it is designed to measure the exact expense incurred, or the reduction in income actually brought about by the rain, or both.

Earthquake Insurance

In the earthquake form, used in eight Pacific coast and Rocky Mountain states to extend the fire contract to cover earthquake losses or to transform a fire policy into an earthquake policy, the most important changes made are the substitution of the word "earthquake" for "fire" wherever it occurs and the elimination of those provisions in the standard fire policy that do not apply to earthquake insurance. No attempt is made to define an earthquake other than by the use of the term "earthquake" to describe the phenomenon that causes loss, but an attempt is made more sharply to define the risk by providing that "if more than one earthquake shock shall occur within any period of seventy-two hours during the term of this policy, such earthquake shocks shall be deemed to be a single earthquake within the meaning hereof." Since earthquake damage is usually partial, the endorsement includes an average clause. A deductible of at least 5 per cent of the value of the property (for some classes of risk, 10 or 15 per cent) is required.

In other states a special contract form is used, which covers loss by volcanic eruption as well as by earthquake, contains no mandatory deductible, and is written independently of the fire-insurance contract, though an endorsement on the fire contract may be used for dwelling risks in some of these states.

Credit Insurance

Credit-insurance contracts afford to manufacturers or wholesalers protection against abnormal credit losses. The terms of the contract are complex and vary from risk to risk, depending on the amount of primary loss to be borne by the insured, the credit practices of the insured, and on collection arrangements.[9]

Title Insurance

Title insurance is an outgrowth of the attorney's examination and certification of title to real estate, which contains his opinion, but no guarantee, as to the state of the title. If negligence of the attorney or his employee can be proved, a damage suit may be successful, but recovery is dependent upon his financial responsibility. Under the title-insurance contract, the insurer agrees to indemnify the insured up to the limit named in the policy against loss due to defects in the title to the real estate covered, subject to the exceptions recited

[9] For extended discussion of credit insurance and title insurance, see Robert Riegel and Jerome S. Miller, "Insurance Principles and Practices," chaps. 39 and 40.

in the policy. These exceptions are such limitations on the title as encumbrances, covenants, building restrictions, or easements. This contract does not cover against an event to occur at any time in the future, but against loss that may be sustained in the future owning to defects existing, but undiscovered, at the time it is issued. A single premium is paid at the time of issue, the greater part of which is a fee for the service of title examination. It is not, like the ordinary insurance contract, a contract of indemnity intended to spread uncertain future losses over a group exposed to them. Rather, the service performed by the company is an attempt to prevent loss from defective title by careful examination, the results of that examination as set forth in the policy being supported by a financial guarantee.[10]

Errors and Omissions Insurance

Banks and other similar financial institutions may insure against loss due to oversight in not being properly protected by insurance on property pledged as security for a loan. Such insurance is written in connection with real-estate mortgages and financing of the purchase of automobiles.[11]

Aircraft Insurance

While insurance incidental to aviation is a highly specialized branch of the insurance business, the various covers are much the same in character as those used in the automobile-insurance field. Hull insurance covers loss to the aircraft; liability insurance covers loss due to liability of operators of aircraft to passengers and others, as well as that of airport operators, hangar keepers, and dealers; workmen's compensation insurance is of the same nature as that written for employers in other activities.

Livestock Insurance

Livestock insurance covering death of insured animals has been practiced from ancient times by mutual-benefit associations. It is carried on at the present time both here and abroad by many small associations and to some extent by commercial insurers. Despite the extent of the dairy and meat-cattle industries it is not commercially important. The major impediment is moral hazard.

[10] In some areas a Torrens system provides an alternative approach. See p. 613.

[11] Professional liability insurance mentioned on p. 240 is also sometimes called *errors and omissions* insurance.

Two conditions make it very hard to control. Unless an animal has an individual mark distinct from the herd mark, it is usually impossible so to identify it as to permit individual insurance. If a herd is covered, it is difficult to keep a proper ratio of insurance to value. The kind of care, feeding, and protection given the animals is of greatest importance in determining the chance of loss, and there is no satisfactory way of checking up before loss and little chance of proving neglect (or worse) after loss.

In a brief time highly valued breeding or competitive stock may become almost worthless. Even though an owner may not willfully neglect or destroy such animals, he may lose his desire to preserve them.

Because of the nature of the hazard, the contract contains a rather formidable list of exceptions to its general liability for loss.

Livestock may be covered against loss by fire or lightning and the extended-coverage perils under an ordinary fire-insurance contract. Electrocution, freezing, and theft are among the additional perils that can be added by endorsement. Contracts may also be written under inland-marine forms.

Records Destruction Insurance

Records destruction insurance covers either or both of two possible types of loss. The first is loss by destruction of "valuable papers," such as books (including printed books and books of record), manuscripts, maps, films, drawings, abstracts, deeds, and mortgages. The measure of loss is the cost of repairing or replacing, except that specifically insured items may be covered for agreed amounts which are recoverable as the amount of loss in case of destruction. The second type of loss is that of amounts that cannot be collected because of destruction of records of accounts receivable.

Loss from any cause, subject to stated exceptions, is covered.

Nuclear Energy Insurance

The development of nuclear energy has introduced two new types of loss, loss to property caused by nuclear energy and injury to persons. To meet these results of nuclear hazards, contracts covering the insured's loss of his own property and his liability for injury to other persons and to their property have been developed, as such losses have been generally excluded from the coverage of other contracts.

Nuclear energy property insurance protects the operator of a nuclear reactor against damage to the reactor itself and his other property on the described premises as a result of a nuclear explosion or *any other peril not specifically excluded.* For firms with lesser nuclear hazards, radioactive contamination

insurance is available. Nuclear energy liability insurance covers liability arising out of nuclear incidents. An unusual feature is that the insureds include the named insured and *any* other person who may be held liable for the loss. The other person, for example, may be a negligent motorist who collides with the facility.

Miscellaneous Unusual Coverages

Illustrative of the unusual coverages that are available from a limited number of insurers, perhaps only from insurers outside the United States, are valued business interruption insurance, confiscation insurance, and all-risks blanket worldwide protection against direct real and personal-property losses on a replacement-cost basis, against rent losses, and against business-interruption losses.

QUESTIONS

1 A store owner is insured against loss by burglary. After business hours, a thief, who finds a door unlocked, enters and steals merchandise. Is the loss covered?

2 A boiler-and-machinery-insurance contract includes as one of the "objects" a certain steam boiler and specifies a limit of $15,000 per accident. The boiler explodes, causing a loss of $10,000 to the insured's property. In addition, a claim for $15,000 damages is made against the insured by a person who was passing the plant and who was injured by the explosion. After suit, damages of $10,000 are awarded. Expense for investigation of the claim and defense of the suit amounted to $2,000. What is the liability of the insurer? Itemize.

3 Glass losses tend to be small but frequent. Why is glass insurance popular?

4 It has been said that title insurance guarantees to the insured that he will not be ousted from possession of the property the title of which is the subject of the insurance. Is this statement correct?

5 Explain the losses that may arise as a result of destruction of valuable papers, and their coverage under insurance contracts.

6 What hazards have been introduced by the development of nuclear energy?

21
LIFE-INSURANCE AND ANNUITY CONTRACTS

Life-insurance and annuity contracts are both concerned with life contingencies. A life-insurance contract provides funds when the insured person dies; an annuity contract provides the annuitant with an income as long as he lives. This chapter deals with the nature of the losses that these contracts are designed to cover, the principal types of individual life-insurance and annuity contracts, and the most important contract provisions.

NATURE OF THE POTENTIAL LOSS

Families and businesses both face potential losses, the financial consequence of which can be alleviated through life-insurance and annuity contracts.

Family Losses

The principal family loss with which life insurance deals is that of *loss of future income* due to the untimely death of the income producer. But what is untimely death? Some men cease to be income producers at an early age and, because of sickness or deformity, their prolonged life involves not only no continuance of income but continued expense. Others continue in active life as producers until they reach an advanced age, sometimes of necessity to care for themselves or those dependent upon them and sometimes from choice. There is no age at which it is generally true that, thereafter, there is no loss of income caused by death. However, the death of an active worker prior to his normal retirement age, say sixty-five, would generally be agreed to be an untimely death. Most persons tend to underestimate the magnitude of the loss of future incomes associated with such deaths. To illustrate, if a person aged 35 and earning $10,000 a year after taxes should die, what would be

the loss of future income to his family under the following two assumptions? First, assume that if he does not die there would be no change in his future income until he retires at age 65. Second, assume that it costs $2,000 a year during his working life to feed, clothe, shelter, and otherwise maintain himself. In such a case the loss to his family is $8,000 a year for 30 years.[1] This method of estimating the potential loss involves many assumptions which may turn out to be incorrect, but the estimate need not be perfect to be useful. In addition to underestimating the general magnitude of the loss, many persons do not realize that the loss of future income tends to decrease with age. For example, if the person whose situation was described above had been aged 55, the future income loss would be $8,000 a year for only 10 years.[2]

Death also creates *extra expenses* in the form of funeral expenses, probate costs, estate and inheritance taxes, and other expenses involved in the rearrangement of family affairs.

The risk of *"living too long"* is also a problem. After a person retires from active employment, his earnings stop or are reduced, but he must continue to maintain himself and perhaps some dependents. He must save in anticipation of this time, but because he does not know how long he will live after his retirement, his savings goal is uncertain.

Business Losses

To the extent that a business is interested in the welfare of its employees, it is concerned with the family losses described above. This interest may be generated by humanitarian attitudes, enlightened self-interest, union pressures, or a fear that government programs will expand unduly unless private businesses provide adequate protection. The extensive employee-benefit plans described in Chapter 23 are the result.

The death of an employee or owner, however, may cause direct losses to the business itself. The *death of a key employee* can cause a business to suffer a temporary or permanent reduction in net income because of his special talents as an engineer, an executive, or a salesman or in some other capacity. Even if the key employee can be replaced within a fairly short period of time, the replacement may demand a higher salary and may have to be trained.

Small businesses face special problems when one of the owners dies. For

[1] At 5 per cent interest compounded annually, the present value of $8,000 a year for 30 years is $122,980. This sum invested at 5 per cent would permit the annual withdrawal of $8,000 a year at the end of each year for 30 years before the fund would be exhausted. This present-value concept provides a lump-sum measure of the loss.

[2] At 5 per cent compounded annually, a lump-sum equivalent of $61,774.

example, if one of several partners dies, the surviving partners may not be willing to constitute a new partnership with the deceased's heirs because of personality conflicts or the heirs' lack of interest or ability. Consequently the business may have to be liquidated unless the partners entered earlier into a buy-and-sell-agreement under which the surviving partners agreed to buy the interest of the deceased from his heirs and the deceased obligated his heirs to accept their offer.

Businesses extending credit through loans or installment-payment sales often find that the death of a debtor reduces the likelihood that the repayments will be made.

Unique Characteristics

The risks with which life insurance is concerned have certain fundamental characteristics that differ from those of other kinds of insurance, as follows:

1 The event insured against (death of an individual) is bound to happen. If the time element is disregarded, there is no uncertainty. The risk is not that loss will occur because a person dies, but that he may die within a particular interval of time.

2 The hazard increases from year to year. In any group of persons, all selected by the same standard, the probability of death of each person increases with increase in age.

3 There is no possibility of partial loss.

4 It is impossible to place an accurate monetary value on human life. In the case of physical property, the cost of reproduction is the limit of possible loss. In the case of liability for damage, judgments determine the value of a life and are expressed in monetary terms. Even in the case of temporary disability caused by sickness or accident the difference between income earned before the illness or injury and that immediately after is a measure of loss. To determine the value of the income-producing power of a life, it would be necessary to know what the income would be through the remainder of life. Although the estimates of the potential loss of future income described earlier are useful for planning purposes, they are not accurate enough to serve as a basis of loss adjustment under an insurance contract.

5 The risk is little affected by the personal characteristics of the beneficiary to whom the insurance is payable.

6 The person insured, who usually negotiates the contract, is dead when it matures as a death claim and, therefore, cannot give his side of the case in event of dispute over a claim.

7 Although the probability of death at particular ages changes with the

development of preventive medicine and other life-prolonging characteristics of civilization, it changes so slowly that it is possible, from past experience, to construct tables that measure with reasonable accuracy, for a considerable term into the future, the probability of death at each age of a given type of person.

8 The subject matter of the insurance may change from an asset, against the loss of which insurance is desirable, to a liability to meet which advance provision is desirable; for an individual who is, during his active years, a producer of income for himself and others may live to see the time when he can no longer produce, though he remains to consume. Unless he provides for this contingency in advance, he will be a dependent consumer.

Reflection in Contracts. These fundamental characteristics of the subject matter are reflected in the forms and practices of the insurance business. The following are distinctive characteristics of life-insurance contracts:

1 All policies are valued policies. Though only one with an insurable interest in the life insured may take out such a policy, the insured has been held to have an unlimited insurable interest in his own life and may assign his policy at will. The contract is not a contract of indemnity since payment will be made to the designated beneficiary without proof of financial loss.[3]

2 Policies may be, and for the most part are, issued covering the whole term of life.

3 Even though the premium payable remains the same (subject to some exceptions), probability of loss increases each year.

4 Since a *net* level premium to cover an increasing hazard implies an overcharge in the early years which must be invested and conserved for later years, there is an investment element in life insurance. The accumulations over current cost are measured by the *reserve.*[4]

5 A wide variety of contracts is in use, blending investment and insurance in various degrees.

6 There is no provision for cancellation, though the insured may discontinue the insurance by nonpayment of a renewal premium. If he does so, his equitable share of the investment feature of the contract, the *cash value* (if any) of the policy, is made available to him.

7 Since the policy is a valued policy covering total loss (death) only, it is usually necessary, in establishing a claim, to prove only three things:

[3] Even under Texas law, most beneficiaries are not required to prove an insurable interest in order to enforce payment.

[4] See Chapter 28.

that the contract is in force, that the insured is dead, and that the claimant is the beneficiary named in the policy. There is no need of elaborate claim procedure, nor of extensive provisions for settlement of loss.

8 The insured may usually change the beneficiary as he desires, without consent of the insurer.

9 The contract is *incontestable* after a stated period following the date on which the contract comes into force.[5]

10 In addition to life-insurance contracts providing a sum for the beneficiary on the death of the insured, annuity contracts and endowment-insurance contracts provide for payments contingent on the continued life of the insured.

Other differences in practice also flow from the peculiar character of the subject matter but do not affect the form of the contract.

BASIC TYPES OF LIFE-INSURANCE CONTRACTS

There are two fundamental types of contract based upon life contingencies:

1 *Insurance,* under which the benefit is paid if death occurs within a time limit, which may include the whole of life.

2 *Pure endowments,* under which the benefit is paid if the life survives a set time limit, the *endowment period.* A series of pure endowments in which the payments are at 1-year or shorter intervals until death is an *annuity.*[6]

Insurance and endowment may be, and often are, combined in the same contract, properly termed "endowment insurance" but popularly known as an "endowment." Pure endowments are seldom issued. The basic types of insurance contracts issued on an individual basis are described below. The special characteristics of group life insurance are described in Chapter 23.

Term Contracts

Life insurance payable only if death occurs within a fixed time limit is provided under term contracts. They are sometimes issued for 1 year only, more often for 5 or 10 years, and sometimes for 15 to 20 years or even for longer periods. The face amount may be level over the period or it may change (usually decreases).

[5] See p. 311.

[6] Strictly speaking, this is a *life* annuity. Any series of periodic payments, whether or not contingent upon survival of a life, is an annuity. An annuity for a specified period, not dependent upon life contingencies, is an *annuity certain.*

Term contracts may be made renewable one or more times (at increased rates) at the option of the insured; such policies are *renewable-term* contracts. They may also provide for conversion within certain time and age limits to another form of contract, without resubmission of evidence of insurability to the insurer; such contracts are *convertible-term* contracts. Term contracts may be both renewable and convertible.

Conversion may be made in either of two ways. The more popular way is to have the new contract issued as of the insured's attained age at the date of conversion. It is generally permissible, however, to have the new contract issued as of the original date of the term contract, and with a premium as of the original age, by the payment of some amount such as the difference between the premiums on the new contract and those paid on the old accumulated at compound interest.

The premium rate for 1-year term insurance (if quoted) is the lowest for which a separate contract of life insurance may be purchased. Premium rates (level throughout the policy period) for 5- or 10-year term are a little higher. But for each successive year the rate for 1-year term increases, as does that for longer terms with each successive period.[7] Term insurance issued in combination with a whole-life contract is usually written at a lower rate than under a separate term contract.

A term-insurance contract is suitable for furnishing temporary protection to cover a business risk, as for example the risk a contracting firm runs through chance of the death of its chief engineer before the completion of a particular job. If renewable and convertible, it may be used to protect the family of a young professional man during his years of low income, while building up his practice. Most mortgages are now amortized by annual payments that reduce the amount of the mortgage debt each year until, at the end of an agreed period, it reaches zero. The *mortgage-redemption* contract is designed to meet the needs of a mortgagor under this type of mortgage. This contract provides decreasing term insurance, the amount of insurance for each year of the currency of the mortgage being at least sufficient to pay the outstanding mortgage debt, the insurance itself reducing to zero at the expiration of the mortgage.

Whole-life Contracts

Insurances extending over the entire term of life, at a premium rate fixed in advance and stated in the contract, are *whole-life* contracts. The premium may be payable throughout life, limited to a term of years, or even be a single

[7] For a comparison of rates for various types of contract, see p. 309.

payment. On the basis of these three methods of payment, there are three types of contract: *straight life* (also called *ordinary life*), *limited-payment life*, and *single-premium life* (a form of limited-payment).

The straight-life contract is the lowest-priced form of permanent[6] life insurance, since its premium is sufficient to cover the future risk and keep the rate from rising in the later years. It is adapted to the needs of most persons requiring permanent protection. It contains an investment element, since the premium in the earlier years is greater than is necessary to meet current cost, the excess being conserved for future needs. The nature of this investment element is described more fully on pp. 307–308.

Limited-payment contracts may be issued for a single premium or with a premium-paying period of any desired term of years. Such contracts are also written so that the premium-paying period will end at a given age, e.g., 60 or 65; they are called "life paid up at 60" (or "65"). Often the insured buys a limited-payment contract in the expectation that the end of the premium-paying period will coincide with a drop in income or an increase in other expenses. Since the insured promises to pay premiums for a period that may be less than the whole of life, the premium rate for a limited-payment contract is higher than that for straight life, increasing as the period of payment decreases. The premium for a single-payment contract is highest. If ability to stop paying premiums at some future date is a relatively unimportant factor, a straight-life-insurance contract has the advantage that it provides more protection for the same annual premium, without much of a reduction in the investment element.

There is a wide variety of special plans of premium payment to suit varying needs. *Modified-life* contracts provide for a low premium for 3 or 5 years, and a higher premium thereafter. Arrangements may be made for term insurance for, say 2 or 5 years, which changes automatically to straight life insurance at the end of the term. If it is desired to have the regular contract take effect on a specified date, less than 1 year hence, but to have immediate protection, preliminary term insurance for a period of less than 1 year may be effected by endorsement.

Certain insurers write *preferred-life* or *special* contracts on selected risks for minimum amounts such as $10,000 at a lower rate per $1,000 than is charged for the equivalent contract written for smaller amounts.

Endowment Insurance

Endowment insurance is a combination of insurance and pure endowment, of a term insurance for a specified time and a pure endowment for the same period. It is, therefore, payable at its face if the insured dies within the en-

[6] "Permanent," in life-insurance jargon, means for one's entire remaining lifetime.

dowment period, and at the end of the period if he is alive. Since the insurer must have the money in hand to pay at the end of the endowment period, there is a larger investment element in this form than in either of the others considered.

The endowment period may end at some fixed age or run for a fixed number of years. Twenty years is the most common fixed term, though policies for longer and shorter terms in multiples of 5 years are also issued. Most endowment-insurance policies are issued with a premium-paying period equal to the endowment period. But they may also be issued on a form limiting the payments to a shorter term of years.

The Investment Element in Life Insurance

All basic policies other than term insurance include a savings or investment component. Indeed, they can be viewed as a package of increasing savings and decreasing term insurance. The increasing savings under a whole-life insurance contract must equal the face amount at the age (usually 100) in the mortality table at which all insureds are assumed to be dead. The increasing savings under an endowment policy must equal the face amount at the close of the endowment period. Whole life insurance is, therefore, in effect endowment insurance to the limiting age.

As an investment, life insurance has many attractions. Insureds saving in this way are likely to accomplish their savings objective because of periodic premium notices, the loss of protection if a contract is surrendered for its cash value, and some reluctance to exercise the loan privilege. Life insurance has always been a relatively safe investment, even during the depression of the 1930's. If the insured dies, the savings component, like the protection element, passes directly to the beneficiary and thus escapes probate costs and delays. As will be indicated later, the cash value may be converted into an annuity at some future date. A minimum rate of return is guaranteed and the actual rate of return in the long run compares favorably with that on many other investments, particularly since it is subject, at most, to some deferred income taxation.[9] On the other hand, the return does vary among insurers

[9] If the insured surrenders his contract for a lump sum, the difference between the cash value and the premiums paid is taxable income. However, this amount is frequently negative and is almost always small because the premiums paid include the pure protection cost and the insurer's expense loading. Furthermore, if the amount is positive, the impact of the taxation may be lessened by prorating the taxable amount over the year of receipt and the two preceding years. Finally, the insured may be in a lower tax bracket than he was during the premium-paying years.

If the insured surrenders his contract for a life annuity under a settlement option, no tax is payable on the exchange but a portion of each annuity payment is taxable. The excluded proportion is obtained by dividing the cash value (which is the purchase price of the annuity) by the annuity payments that the individual would receive over his life expectancy.

and among types of contract. If the insured surrenders the contract after a few years, the return will be very low. Finally, life insurance is subject to the limitations of other fixed-dollar investments in periods of rising prices and a growing economy. Hence the insured may reasonably compare it with other investments he might make during the same period. He may well decide to invest in many different media, including life insurance.

Because equity investments have claimed an increasing share of the consumer's savings dollar since World War II, many insurers have started to sell the equity-based products described on pages 321–322 in addition to more conventional life-insurance contracts.

PREMIUM RATES

Knowledge of price and the manner of its payment is essential to an understanding of the contract. One's decisions between life insurance and other means of preparing for the future, and between different forms of life-insurance contracts, are based, often largely, and usually to some extent, on considerations of price and terms of payment. Careful fitting of contracts to the circumstances of the insured is a praiseworthy development of modern life insurance. Not the least of the circumstances to be considered are the availability of funds to pay premiums and the variations in that availability over the contract period.

Participating and Nonparticipating Contracts

Participating and nonparticipating insurers will be discussed later, but it should be noted at this point that most life-insurance contracts are written on a participating basis. Provision is made for *dividends* to insureds, if the income of the insurer is sufficiently in excess of its needs. Under nonparticipating contracts the quoted premium rate is the final cost of the insurance. Each insurer calculates and quotes its own rates.

Since 1958, life insurers have quoted premium rates (per $1,000 of insurance) which decrease with the amount of insurance. Properly to compare rates for participating and nonparticipating insurance, the comparisons should be made for contracts of the same amount. The rates in the following table are for a straight-life policy issued to a man of 35.

The out-of-pocket cost of insurance to the insured, under participating contracts, is the difference between the total premiums paid and the total dividends received, unless the contract is discontinued before maturity, when any cash value (the savings element) received by the insured should also be deducted. Under a nonparticipating contract, only the cash value would be

deducted in case of discontinuance. It is common practice to compare costs by deducting the cash value *available* at the end of any period for which cost is to be determined, say, 10 years. However, this method ignores the loss of interest on the money paid as premiums. Still more important, it assumes that the insured will claim the cash value at the close of the period for which the cash is calculated.[10]

Table 21–1 ILLUSTRATIVE COMPARATIVE RATES OF NONPARTICIPATING AND PARTICIPATING INSURERS FOR STRAIGHT LIFE INSURANCE

Amount of insurance	Insurer A (nonparticipating)	Insurer B (participating)
$ 5,000	$19.62	$23.57
10,000	18.82	22.77
20,000	18.42	22.37

Costs for similar contracts with different insurers are frequently compared. Of necessity, only past costs can be determined, but it seems reasonable to expect that a participating insurer with a long record of approximately the same cost position in relation to other participating insurers will maintain that position in the future. Relative costs as between participating and nonparticipating insurers depend in large measure on general rates of mortality, of expense, and of interest, particularly the last. In the case of an individual insurer, its own mortality, interest earnings, and expenses will determine cost.

The relative rates for several common forms of contract at different ages are shown in Table 21–2. For simplicity, the rates of a large nonparticipating insurer are used.

Table 21–2 COMPARATIVE RATES CHARGED BY ONE INSURER FOR NONPARTICIPATING LIFE INSURANCE

Rates per $1,000 for a $10,000 policy issued to a man*

Age of insured	Type of contract				
	Nonrenewable 10-year term	Straight life	20-payment life	Paid-up at 65	20-year endowment
25	$ 5.13	$13.56	$22.94	$15.78	$43.98
35	77.03	18.82	29.03	22.97	44.89
45	12.68	27.79	37.65	37.65	47.86
55	26.57	41.78	50.27	80.21	55.14

* For a woman, the rate is generally the same as for a man 3 years younger. Rates per $1,000 decrease for amounts larger than $10,000 and increase for smaller amounts.

[10] For a more sophisticated approach, see J. M. Belth, "The Retail Price Structure in American Life Insurance."

Premiums Paid Oftener than Annually

Rates for life insurance are quoted per $1,000 of insurance per year, but one may arrange to pay semiannual, quarterly, or monthly premiums. To determine the semiannual premium, the annual premium is increased by a percentage and the result divided by 2; to determine the quarterly or monthly premium the annual premium is increased by larger percentages and the result divided by 4 or 12. If the annual premium is increased by 3 per cent as a basis for determining the semiannual premium, the insured is paying the equivalent of approximately 12 per cent per annum for the privilege of postponing payment of one-half of his premium 6 months. If he dies during the first 6 months of the policy year, the insurer usually waives the payment of the second semiannual premium for that year. Similarly, if premiums are payable quarterly or monthly, it is usual to waive any premiums for the current year not yet payable at the date of death.

The extra charge covers loss of interest, the extra expense of collection and bookkeeping, and the cost of waiving installments of premiums due after death within the contract year. But the insured may well compare it with the cost of borrowing money in order to pay premiums annually, or may consider the possibility of securing the convenience of periodic payments by accumulating the annual premiums in a savings account. The latter course would require initial funds to meet the payment of the first premium.

Most insurers are now offering to write contracts providing for monthly premiums under a *preauthorized check plan.* Under this plan the insured authorizes the insurer to draw checks for his monthly premiums, which his bank agrees to honor, the insurer guaranteeing the bank that it will incur no loss from handling the checks. This plan eliminates premium notices to the insured, enables him to budget his premiums monthly, and generally is written at lower monthly premium rates than obtain where the insured pays monthly premiums direct. There are other plans similar in nature and purpose.

SOME IMPORTANT CONTRACT PROVISIONS

Risk Transferred

The definition of the risk transferred under a life-insurance contract is quite simple. The contract is a conditional promise to pay, the condition being the receipt of due proof of the death of the insured and surrender of the policy properly receipted, except in the case of an endowment or a term contract. In the former, the promise is to pay the insured if living on the maturity date of the contract, or to pay the beneficiary on receipt of due proof of the death

of the insured before that time. In the latter, there is inserted, after the name of the insured, language to indicate that death must have occurred prior to the expiration of the contract.

The term of the contract is further limited by the requirement for regular payment of premiums, it being provided that the payment of any premium shall not continue the contract in force beyond the due date of the next premium.[11]

Formerly, the risk of travel and residence in certain parts of the world were not assumed under the contract, but most modern contracts are free of such restrictions and, to emphasize the change, it is usually so stated in the contract.

Suicide within 1 year from the date of the contract is a risk not assumed.[12] The clause providing for this exception may appear unduly harsh because of the presence of the words "sane or insane" in connection with the suicide. This language is due to the decisions of some courts that suicide is itself proof of insanity. The exception is a method of controlling moral hazard. It is believed that there is little likelihood that a person contemplating suicide and desiring to protect dependents will take out a policy and wait a year or more before carrying out his intention.

By custom and statutory requirement, contracts are made *incontestable* after 1 or 2 years from the date of issue, except for nonpayment of premium. Even if the insured obtains the contract through a fraudulent misrepresentation regarding, say, visits to a doctor, the insurer cannot contest the validity of the contract unless it does so within the specified 1- or 2-year period.

The occupation of the insured is carefully examined in passing on the application, and his past occupations and expectations of change are carefully inquired into. By agreement in the application and reference in the policy, the contract may completely exclude a specified hazard. If the contract, with the exclusion, is not acceptable to the insured, an extra premium may be charged or the risk declined.

War Risk. Under ordinary conditions there are no exceptions to the liability of the insurer to pay the proceeds of a life-insurance contract after the incontestable period has expired. But when war is imminent or in progress, the risk of death as a result of war becomes too great to be absorbed as a part of the total risk assumed by the insurer.

This situation is met by adding a clause to the contracts of insureds who, in the judgment of the insurer, are likely to be exposed to such risk, exempting the insurer from liability for death caused by war, under conditions specified in the clause. The clause is ordinarily used only when it becomes thoroughly

[11] But see p. 314–315, Nonforfeiture Values, and p. 315, Automatic Premium Loans.

[12] The contracts of some insurers specify 2 years.

impractical not to do so, for insurers are loath to depart from their unqualified promise to pay. In time of war it is usually added to all new contracts.

Provision is made for the return of premiums or other equitable adjustment in cases where the clause is operative. It is customary to waive exemption under these clauses once the danger has passed.

Inception of the Contract

The life-insurance contract usually provides that it goes into force on delivery of the policy to the insured in good health, the first premium having been paid. Actual physical delivery is not necessary if it can be shown that delivery was intended, though actual delivery makes it simpler to prove that the contract is in effect. Possession of the policy is not conclusive proof of delivery, since it may have been put in the hands of the insured for examination.

A *conditional receipt* or *binding receipt* for the first premium may provide that the insurance will take effect on the date of the application (or perhaps the date of the physical examination) if the insurer decides later that the applicant was acceptable on the earlier date. For example, if a person receives such a receipt and is killed in an automobile accident between the date of his application and the date the insurer accepts his application, the insurer must pay the claim. The insurer must decide whether the applicant is acceptable on the basis of his insurability when he applied for the insurance. The accident is not a factor in this determination.

Consideration

Unlike the practice in many other kinds of insurance, life-insurance policies are not issued by agents but by the home office only, and on the basis of a written application which is made a part of the consideration for the contract. The application is in two parts: the first, or application proper, which is taken by the agent, identifies the insured and indicates the kind of policy desired, its amount, the name of the beneficiary, and other facts required properly to write the policy; the second, or Statements to the Medical Examiner, contains the applicant's representations with regard to his past history, habits, physical condition, and other factors indicating the character of risk he is likely to be. Under the standard-provisions statutes in most, if not all, states, the policy constitutes the entire contract, and in order to bring in the application as a part, a copy, usually a photostat, is attached to the policy. In most states, it is prescribed by statute that the statements of the insured shall, in the absence of fraud, be deemed representations and not warranties. No statement may be used in defense of a claim unless it appears in the copy of the application.

The premium and its periodic payment are also a part of the consideration for the contract. Some companies make the policy a receipt for the first premium; others do not.

Since the premium is based on the age of the insured, it is important that the age be correctly stated. One of the statutory standard provisions is that, if the age has been misstated, the amount of the policy shall be such as the premium would have purchased at the correct age of the insured.

Optional Methods of Settlement

Most contracts offer several options for the payment of the proceeds (including the cash value) of the insurance, whether they are payable to the insured or to his beneficiary. However, if the insured has exercised an option providing for payment to the beneficiary, the latter is bound by it, unless permitted by the contract to change it. These options are in lieu of payment of the proceeds in one sum.

The options commonly offered are (1) installment payments, each of a specified amount, (2) installment payments for a specified period, (3) life income with or without installments guaranteed for a stipulated period, and (4) leaving the proceeds with the insurer at interest, often with a limited privilege of withdrawal.[13] While only the options included in the contract may be exercised at will by the insured (or beneficiary), other arrangements for the payment of proceeds may be made with the insurer if its rules and the law permit.

These optional, or other, methods of settlement enable the insured or his beneficiary to adjust the payments to their needs. And there may be important tax advantages in spreading payments over a period of years instead of having the proceeds paid in one sum.[14]

Trust Management of Proceeds. An insurer may accept the responsibility of paying the proceeds of a life-insurance contract only in ways that do not

[13] The interest may not be left with the insurer to accumulate; it must be accepted by the insured as it becomes payable.

[14] Lump-sum proceeds are exempt from federal income taxes. Interest paid under the the interest option (4), is taxable income. Payments made under the other three options are partially taxable; the excluded proportion is obtained by dividing the proceeds applied to that option by the total payments over the specified period under the first two options or over the beneficiary's life expectancy under a life-income option. A further adjustment is necessary if the life-income option includes some guaranteed installments.

Spouses receiving payments under any option other than the interest option have a special exemption of $1,000 applicable to the taxable portion of those payments.

require any exercise of discretion. In other words, it may agree to make payments at definite times in accordance with the occurrence of definite events, but not otherwise. Furthermore, an insurer prefers not to undertake highly complicated settlements.

Greater flexibility of management may be secured by making the proceeds payable in one sum to a trustee, usually a trust company, for management under a trust agreement. Such an arrangement, however, involves a fee to the trustee and a greater risk of loss of capital. A trust is managed as an independent financial unit, while the entire assets of an insurer are security for all its obligations. A trust of this sort is usually suitable only for a rather large fund.

Nonforfeiture Values

Premiums for life insurance are, in most cases, level in annual amount over considerable periods, while the cost of providing the insurance increases from year to year. During the early years of a contract the insurer must collect premiums that are in excess of the cost of providing the insurance and accumulate this excess at interest to meet the deficit of the later years. As a consequence, if the insured ceases payment of premiums before the end of the premium-paying period and is still alive, some adjustment must be made to give him the benefit of the excess amounts that he has already paid. This adjustment is provided for by granting nonforfeiture values, so called because the insured, instead of forfeiting all interest in the contract on default in payment of a premium, is entitled to the value of his preceding excess payments.

Usually at the end of the second policy year, but in some cases at the end of the first, the insured may elect to take the value of his policy in cash, *cash value;* as a reduced amount of insurance payable at the same time and under the same conditions as the original amount, *paid-up* insurance; or the original amount of insurance for a term of years, *extended-term* insurance. The reduced amount and the length of the term will be whatever the cash value, as a *net* single premium, will pay for. If the cash value is elected, the insured usually can request that it be paid to him in accordance with an optional method of settlement. For example, he may request that it be paid to him in the form of a life income.

If the insured does not elect one of these nonforfeiture values, extended-term insurance is usually automatic.

Under a typical straight-life contract issued at age 25, the nonforfeiture values per $1,000 of insurance, after 20 years, are as follows; cash value, $250; paid-up insurance, $545; or extended-term insurance equal to the face amount of a contract for a term of 22 years, 75 days.

If the insured is under any indebtedness to the insurer, the values and amount or period of insurance will be appropriately reduced. Contracts for short terms of not more than 15 years expiring at or before age 65 do not provide for nonforfeiture values.

Loans

The insured is entitled to borrow from the insurer up to an amount which, with interest, will not exceed the cash value of the policy (less any existing indebtedness). Interest is usually at the rate of 5 per cent. Within the limit, the insured may borrow whatever amount he chooses and may repay the loan in such amounts and at such times as he chooses. When the insurance becomes payable, any outstanding indebtedness is deducted from the proceeds.

Most, if not all, insurers charge the same rate of interest regardless of the amount of the loan. Except in times of generally high interest rates, large loans may more economically be made from a bank, using the policy as collateral, but not with the *same freedom* as to times and amounts of repayment.[15]

It is sometimes suggested that, in making a loan, the insurer is charging the insured interest on his own money. Actually the loan is a separate transaction, and the interest covers not only the use of the funds but the expense of handling the transaction. One may obtain "his own money" by taking the cash value of his policy but must discontinue his insurance to do so.

A few insurers make provision for term insurance on the insurable borrower for the amount of the loan. On death, proceeds of the term insurance are applied to the reduction of the indebtedness, avoiding reduction of the proceeds of the original insurance to that extent. One might, of course, buy independent insurance for the same purpose, though it would be difficult to adjust it to the exact amount of the outstanding loan.

Automatic Premium Loans. Many insurers will make effective a provision for automatic premium loans on request by the insured.[16] Under this provision, on nonpayment of any premium by the insured, the premium is charged automatically as a loan against the policy so long as the amount of the loan, with an accrued interest or other indebtedness, is within the loan value. The automatic premium loan keeps the contract in force without change but is deductible from the proceeds in event of death before repayment.

[15] During late 1966, when interest rates rose, some insurers faced a serious cash-flow problem because of increased policy loans.

[16] In some cases the provision is effective without specific request.

Disposition of Dividends

Under participating contracts, the insured usually has the option of (1) receiving any dividends in cash, (2) having them applied in reduction of premiums, (3) using them to purchase participating paid-up *additions*, (4) leaving them with the insurer to accumulate at interest, or (5) using each annual dividend to buy one-year term insurance at the attained age. Usually the amount of term insurance under the fifth option is limited to the cash value of the insurance, in which case the excess, if any, of the dividend over the cost of that amount is accumulated at interest. If the insured exercises no option, one of these is automatic.

Privileges (3) and (5) of adding amounts to the insurance by using the dividend as a single premium are usually valuable if the insured needs additional insurance. Most insurers provide the additional insurance on a *net* basis, i.e., without including provision in the premium for expenses. And, in the early years at least, the total payable on death will be considerably greater under this option than if the dividends are accumulated at interest.

Provision is also made for endorsing the policy as fully paid (continued at its face value without further payment of premiums), on request of the insured, when the value of all dividends credited plus the value of the policy equal the net single premium for the face amount. If such credits equal the face of the policy, it may be paid, on similar request, as an endowment—this is not an additional privilege if the insured may surrender his policy for payment of such credits in any event.

Miscellaneous Privileges

Grace Period. If the insured fails to pay any premium after the first on the date when it is due, he is regularly allowed a period of grace, usually 31 days, during which the insurance remains in force without change. If he dies within the period of grace, the amount of the premium is deducted from the proceeds of the insurance.

Change of Beneficiary. By the usual terms of the contract, the insured has the right to change the beneficiary, though he may irrevocably designate a beneficiary, in which case he may not change the beneficiary without the latter's agreement to the change. The insurer is responsible for payment to a new beneficiary only after notice from the insured to make the necessary endorsement, though the change may relate back to the date of signing of the notice.

Rights of Insured. It is usually provided that, during his lifetime, the insured may exercise all the rights under the contract, without the consent of the bene-

ficiary, including the right to change the beneficiary. If the policy is used as security, even in the case of a contract in which the right to change the beneficiary has been reserved, it is considered desirable to change the beneficiary to the insured's estate, so that any claim against the insured for which his policy stands as security may be enforced without valid objection by the former beneficiary.

It is generally provided that on death of the beneficiary all rights of the beneficiary shall vest in the insured. Special provision is often made for succession to the beneficiary's rights in event of simultaneous deaths, or death within a stated number of days after that of the insured.

Reinstatement. After default in payment of premium, not cured by payment within the grace period, the contract may usually be reinstated within 3 or 5 years, if the insurer is furnished with satisfactory evidence of insurability and if stated conditions are complied with. The *right* to reinstatement is usually withheld if the cash value has been taken or if the period of extended-term insurance has expired. Insurers often permit reinstatement even though, under the contract, the insured does not have an express right to it.

Change to a Different Contract. Subject to stated restrictions and conditions, the insured has the privilege of exchanging his contract for another with the same insurer.

Assignment. The life-insurance contract may be freely assigned without the consent of the insurer. The insurer, however, is responsible for recognizing the rights of the assignee only after it has received legal notice of the assignment. The only limitations on the right of assignment are that it must not be made as an evasion of the requirement of an insurable interest or in fraud of creditors. If the insured took out a policy with the intention of immediately assigning it to another who would pay the premiums as a gamble on the life of the insured, and did so, it would be an evasion of the insurable-interest requirement.

Deferment of Obligations of Insurer

The insurer may under most, if not all, contracts defer the payment of cash values or the granting of loans for a period not exceeding 6 months. This provision is the product of what amounted to a "run" on insurers during the

early days of the depression of the 1930's, a situation that was then met by emergency legislation. Advantage of this right is not taken in the usual course of business, but another period of panic or depression might make it necessary to invoke it, quite as much in the interest of insureds as of the insurer.

Payment of Proceeds

The proceeds of a life-insurance policy will be paid without difficulty to the beneficiary on proof of death of the insured, though where death is claimed in cases of disappearance considerable difficulty may be experienced. It is usually a simple matter to determine who is the beneficiary, but questions may arise here. In the case of payments contingent on continued existence, some proof of such existence is necessary, though it is seldom exacted.

If the beneficiary murders the insured, the general rule is that the murderer may not collect and retain the proceeds of the policy. But the insurer must pay, after the expiration of the incontestable period, unless the policy was obtained through fraud by the beneficiary. In most cases of this sort, the proceeds go to the estate of the insured.

Exchanging Old Policies

In addition to the many other serious questions that arise when consideration is given to dropping, altering, or exchanging any life-insurance contract, an insured should give special attention to comparing the terms of his contract with those currently available. Often privileges, rates of interest, and premium rates have changed to such an extent that retention of an old contract is preferable to taking out a new policy.

ANNUITIES

Until recently, annuities were not in much demand in the United States. Americans looked forward to "dying in harness." The struggle was not to attain a competence on which to retire and enjoy life but to amass a fortune. The tendency of corporations to replace private business firms, changing the proprietor to a corporation official subject to retirement as his powers fail, the growing realization that only the lucky few can amass fortunes, increased taxation, as well as losses of investments in times of depression, have brought a change of attitude. The demand for annuities has been growing, particularly since the depression of the 1930's. Group annuities, developed for use in pension plans and described in Chapter 23, have experienced the greatest

growth. Individual annuities, the subject of this chapter, have grown much less rapidly, partly because of the development of group annuities and partly because of the relatively low rates of return made by insurers on their investments in the 1940's and 1950's. As insurers have increased their investment returns in recent years, individual annuities have become much more popular.

Annuities may be, and until recently usually were, paid for by a single premium and provided an immediate lifetime income for the annuitant.[17] Such *immediate annuities* were bought for elderly persons, usually women, who had a modest fortune from the care of which they wished to escape with an assured income for life. They may also be paid for by annual premiums payable over a term of years, the beginning of payments under the annuity being deferred until the end of the premium-paying period. These are *deferred annuities.* This is the form suitable for an earner looking ahead and providing for his own retirement. Sometimes a deferred annuity is also purchased with a single premium payment. In group insurance this is a common practice.

Annuities can also be classified according to the nature of the insurer's promise. Under *a straight-life* or *regular* annuity, the insurer promises to pay the annuity on income as long as and only as long as he lives. Human nature is such that many people object to purchasing simple annuities. They feel that if they die within a short time they will have lost the difference between the consideration they paid and the amount paid them in income. To meet this objection *installment-refund annuities* and *cash-refund annuities* are offered. Under the former the income is continued until the total amount paid equals the consideration. Under the latter the difference between the consideration and the income drawn is paid at the death of the annuitant. Less annual income can be paid under an installment-refund annuity than under a simple annuity, and still less under the cash-refund form. The contract is a little more elaborate under these forms since it must define precisely these additional obligations of the insurer. The yields of annuities depend principally on two forces: (1) the interest rate that insurers are able to obtain on long-term safe investments and (2) the increasing longevity of annuitants. Table 21–3 shows examples of the single premium rates required to provide $100 monthly under a regular, installment-refund, or cash-refund annuity.

There is some difference in the rates quoted by the various insurers, and some insurers issue participating annuities with a lower amount guaranteed but with the possibility of greater actual return when the dividend is added.

Comparison of these returns with the yield of safe securities shows the extent to which one may improve one's annual income by purchase of annu-

[17] Because of the investment problems created by the receipt of large sums in single premiums and the increase in cost of furnishing annuities due to increasing longevity, many insurers have restricted the sale of single-premium annuities.

ities. The lower returns to female annuitants are due to the lower mortality among women than among men.

Table 21–3 COMPARATIVE RATES CHARGED BY ONE INSURER FOR NONPARTICIPATING SINGLE-PREMIUM IMMEDIATE ANNUITIES PAYING $100 MONTHLY

Age	Type of annuity		
	Regular	Installment refund	Cash refund
Male:			
50	$19,610	$20,720	$21,000
60	15,640	17,290	17,690
70	11,400	13,600	14,120
Female:			
50	21,800	22,430	22,590
60	17,800	18,900	19,150
70	13,150	14,910	15,300

Deferred annuities, especially those purchased by annual payments, whether or not of the refund type, may provide for refund of the consideration if the contract holder dies before receiving any payments.

SPECIAL FORMS OF CONTRACT

The forms of contract already discussed are basic. Other forms are combinations or variations of them to meet special needs or to add sales appeal. Contracts under which the insurance is payable on the first death among two or more insureds (*joint life insurance*) are frequently issued. Contracts providing for payment on the last death of two or more insured (*last survivor insurance*) are rarely issued. Joint-life policies are written on the straight-life, limited-payment-life, or endowment-insurance plans, and but seldom on the term plan.

Joint Annuities

A *joint-and-survivor* annuity provides for payment until the last death of two or more persons. It is particularly applicable to the situation of an elderly couple who need the largest possible safe income as long as they live, but who are not concerned with leaving an estate. If each is age 65, an annuity of $100 per month would cost about $18,000, providing a return of approxi-

mately 6.7 per cent per year. A *survivorship* annuity is payable during the period that one person survives another and is really a form of life insurance. A son might feel confident of being able to support his mother, unless she should survive him. Since this contingency is usually remote, he could provide for income during her period of survival by a rather low outlay. These forms of annuity are little used.

Retirement Income Annuity

The retirement income annuity is a popular form that provides insurance up to a specified age, say 65, with a life annuity payable to the insured commencing at that age, usually at the rate of $10 monthly per $1,000 of insurance and with a guarantee of a certain number of payments if the insured enters on the annuity. This annuity combines a deferred annuity with decreasing term insurance. The term insurance decreases because the cash value under the annuity provides an increasing proportion of the death benefit. Because the cash value required to provide $10 monthly at age 65 exceeds $1,000, the term insurance disappears prior to the maturity date and the death benefit becomes the cash value.

Variable Annuities

The life-annuity contract was, until recently and with the unimportant exception of the participating annuity, an agreement to pay a fixed dollar income to the annuitant. The income was a high percentage of the purchase price at the higher ages, but the annuitant faced the possibility, and recently the fact, of inflation reducing the purchasing power of that income.

To meet the risk of inflation, variable annuity premiums are invested in common stocks and other equities, and the income to the annuitant follows the results of these investments. This product resembles a mutual fund in many respects, but it possesses the important unique characteristic that the annuitant is guaranteed a lifetime income. The annual income the annuitant receives at maturity depends upon the performance of the insurer's equity portfolio during the deferment period; this income is adjusted periodically after he retires on the basis of the portfolio's performance during his retirement period. The major argument for variable annuities is that the cost of living and equity values tend to rise and fall together, giving the annuitant a fairly stable real income. Because equity values tend to fluctuate more widely than the cost of living, most insurers recommend that the prospective annuitant also purchase a fixed-dollar annuity to dampen the fluctuations in his income.

Pioneered in 1952 by the College Retirement Equities Fund (an insurer that

sells insurance only to college educators and some closely related occupations), this product has been much discussed. Only a few insurers expressed interest at first in following the CREF lead. Some insurers strongly opposed the marketing of this product by regular insurers on several grounds. For example, they argued that the reputation of the life-insurance business would be damaged if the insurer had to reduce the monthly income under an annuity. They also noted several technical and regulatory problems. This division of opinion, coupled with legal obstacles and the newness of the idea, resulted in little activity outside of CREF until 1964. By that year several states had amended their laws to permit the writing of variable annuities and the Securities and Exchange Commission approved group variable annuities. Individual variable annuities still pose some legal problems, but several leading insurers have already entered this field and others have indicated their intention to do so.

An even larger number of insurers market mutual funds to individuals through their agents. In part this greater activity is the result of legal obstacles associated with individual variable annuities. In part it is because the public has had more exposure to mutual funds, thus making them easier to sell at this time. For the short-term investor, mutual funds also have certain advantages over variable annuities, particularly with respect to the taxation of capital gains. Many insurers plan to market both variable annuities and mutual funds, the first being more suitable as a retirement vehicle and the second as a short-term investment and for accumulating funds to be passed on to one's heirs.

The recent movement of insurers into variable annuities and mutual funds is part of a broader movement by all types of insurers into financial services in general. Their agents are expected in time to become financial counselors dealing in all these services. Through holding companies and subsidiaries some insurers have also moved into consumer loans, commercial banking, real estate development, computer services, and many other activities "complementary and properly incidental to" insurance. A few are associated with companies in completely unrelated activities, such as movie making.

Family-income Contracts

Another appealing contract is in the form of an addition of term insurance, decreasing in amount, to a whole-life contract. Under its provisions, if the insured dies within a specified period from the inception of his insurance, the insurer will pay an income of $10 or $15 per month per $1,000 of insurance to his beneficiary for the balance of the specified period and the amount of the policy at the termination of the period. For example, if the insured takes out

$10,000 of insurance at age 30, includes family-income for 20 years at $10 per month, and dies at age 40, his beneficiary will receive $100 monthly for 10 years and $10,000 at the end of the 10 years. This contract provides decreasing protection as the insured's family matures.

Family-maintenance Contracts

Family-maintenance (or family-protection) contracts are similar to family-income contracts, except that the income continues for the specified number of years from the death of the insured if death takes place within the period. Substituting in the above example, the beneficiary's income would continue for 20 years, and the $10,000 would be payable at the end of the 20 years. Some authorities prefer this contract to the family-income contract as a hedge against inflation or because the insured may have more children at a later date.

Family Contract

The family contract, originated in 1956, is now offered by practically all insurers. It justifies its name by providing insurance on all members of the family, including children born or adopted subsequent to the issuance of the contract. A fairly typical contract issued by one insurer combines each $5,000 of whole life insurance on the husband with $1,250 term insurance to age 65 on the wife and $1,000 convertible term insurance to age 21 on each child. Contracts vary with respect to the proportions in amounts between members of the family, the effect of the ages of the wife or children, the effect of the number of children, and the types of contract on individual members of the family. This contract, like other combination contracts, costs less than the sum of the premiums for the component parts.

Multiple-protection Contracts

The amount of insurance may be multiplied during a specified period. If the insured dies within, say, 20 years, his beneficiary will receive double or triple the amount of his basic insurance. This is simply an addition of term insurance to the whole-life contract.

Guaranteed Insurability Rider

An insured may purchase an option to buy additional insurance at specified dates in the future without furnishing evidence of insurability. For example, a rider attached to a $10,000 policy issued at age 25 may give the insured

the option to add $10,000 at each of tne following ages: 28, 31, 34, 37, and 40. Any option that is not exercised expires.

Juvenile Insurance

The usual lower limit of age for the issue of regular "adult" policies of the types already described is 10, or, in some cases, 5. Nearly all insurers also issue policies on the lives of children at ages below the regular "adult" minimum. These policies are issued on the application of the parent or other person responsible for the child's support.

In some states there are legal limitations on the amount of insurance that may be issued on the life of a young child. For this reason, the amount of most juvenile insurance is graded, i.e., is on an increasing basis during the early years of life, reaching the "ultimate amount" at age 5, 10, or 15. Under some juvenile contracts, in event of death before a specified age, such as 15 or 18, all premiums paid are returned with interest at a low rate. Such a contract does not grant *insurance* prior to the specified age and therefore can be issued for any "ultimate" face amount. The more usual type of juvenile contract, with a graded, increasing *insurance* benefit from the date of issue could not be issued for large amounts unless the amount of effective insurance at the lowest age per $1,000 ultimate amount were very small, so that insurance under a large policy would not exceed the legal limit.

A newer type of juvenile contract (the "jumping juvenile"), written on children from birth to age 14, is sold in $1,000 units at a level premium for its entire term. It continues at its original amount to age 21, when the amount "jumps" to five times the original without evidence of insurability.

Often a provision or rider is added to the contract under which, in event of the death (or frequently also the total and permanent disablement) of the *parent,* premiums are waived until the insured (the child) reaches a specified age, such as 18 or 21. This is called a *premium-protection* provision (or rider) or *payor* clause.

Industrial Life Insurance

Certain life-insurance companies, in addition to issuing the types of policy discussed above, issue policies of small face value on which the premium is payable weekly (or occasionally monthly) and is collected at the door by the agent of the insurer. This insurance is intended principally to provide the industrial classes with funds for funeral expenses, and policies may be issued to all members of the family, including children. The policy forms are similar to, but much simpler than, those in use for larger amounts. The premium is

the unit, the face being adjusted to it in accordance with the age of the insured. They are issued in premium units of 5 and 10 cents per week. Although industrial insurance still accounts for about 7 per cent of the industrial life insurance in force, the amount of industrial insurance in force has been fairly steady for over a decade.

Fraternal Insurance

The fraternal contract is evidenced by a *certificate*, but the contract includes the "application, the articles of association or incorporation, the constitution, and the by-laws of the society,"[18] in which its essence usually is to be found. It is impossible here adequately to treat this form of insurance. The prospective member should examine the contract with care and be sure of full understanding of all its provisions.

Most of the substantial fraternal orders now operate on an actuarial-reserve basis and have largely changed their earlier contracts to conform to that basis. In place of the earlier simple form of certificate, they now issue policies with nonforfeiture values and with most other provisions contained in commercial life-insurance policies.

The fraternal-life-insurance contract is an *open contract*, meaning that the terms, including premium rates, are not fixed even when the society is operating on a legal-reserve basis. The advantage claimed is that, if the society is in financial difficulties, its position may be rectified by readjustment of rates or benefits without insolvency proceedings. Except for this characteristic the policies issued by leading fraternals are practically identical with those discussed earlier in this chapter. Fraternal life insurance is about 3 per cent of the individual life insurance in force.

DISABILITY AND ACCIDENTAL-DEATH BENEFITS

The addition of *disability* clauses to life-insurance contracts was a desirable step in the development of complete coverage. This clause originally covered only disability that was both *total* and *permanent*. Present clauses provide that if total disability has continued for a specified period (3 or 6 months) it will be deemed to be permanent. The benefit may be *waiver of premiums* payable during continued disability or such waiver and, in addition, a monthly *disability income* of $10 per $1,000 of face amount. Disability must commence before a specified age, usually 55 or 60.

[18] Richard de Raismes Kip, "Fraternal Life Insurance in America," p. 108. This study is a valuable source on the history of fraternal life insurance. See also Charles C. Center, "Fraternal Life Insurance."

Overliberal contracts, competitive settlements, inadequate premiums, unfavorable court decisions, and the cupidity of the public led to a general restriction of disability clauses in 1932, but in recent years most leading insurers have reentered the field on a more conservative basis.

These additional provisions are not based on the indemnity principle, the insured being entitled to disability benefits whether or not disability results in financial loss. One insurer, however, issues a separate contract to its life-insurance policyholders under which the insured is entitled to benefits only when disability results in a loss of three-fourths of the insured's income.

The *accidental-death clause* usually provides that an additional amount, equal to the face amount of the policy, will be paid in event of death by accidental means. The required extra premium charge is small. The benefit appeals to the imagination and is often an attractive selling point. If it leads to the sale of more life insurance, it probably serves a useful purpose even though the logic of its inclusion in a life policy is debatable. It may divert the attention of the head of a family from his duty to provide adequately for the future welfare of his dependents and lead him to make less than adequate provision because of the *possibility* of payment of the larger benefit.

Inclusion of either the disability clause or the accidental-death-benefit clause is optional with the insured, if he satisfies the insurer's requirements.

These benefits are subject to special limiting provisions appearing in the respective clauses.

QUESTIONS

1 Jones earns $10,000 a year after taxes. If he should die, how would you determine the financial loss to his family?

2 In selecting a life-insurance contract, what variations in term, in methods of premium payment, and in methods of settlement are available to the prospective insured?

3 The annual premium for a given life-insurance contract is $1,000. The semiannual premium is $510. If the insured can borrow money at 6 per cent per annum, would it be desirable to do so in order to pay the premium annually rather than semiannually, all considerations except premium cost aside?

4 Under what circumstances is it desirable to use dividends under participating contracts to increase the amount of insurance?

5 If premium payments are to be discontinued before the end of the premium-paying period, under what circumstances would each of the nonforfeiture values be appropriate?

6 It is sometimes said that one effecting a loan from an insurer under the

loan provisions of a life-insurance contract is borrowing his own money at interest. Is this statement sound?

7 Under what conditions would each of the settlement options be appropriate?

8 Under what circumstances would it be advisable to purchase a single-premium life annuity? A single-premium life annuity with 10 payments guaranteed?

9 Which of the following two contracts would you recommend to a young man with a family: a family-income contract or a family-maintenance contract?

10 If you were purchasing life insurance, would you have the disability clause included in the contract? The accidental-death clause?

11 What are the advantages and disadvantages of saving through a straight-life-insurance contract?

12 Compare a variable annuity with a mutual fund.

22
HEALTH-INSURANCE CONTRACTS

Health insurance has as its field losses due to accidental injury or disease. Such losses are of five kinds: loss of life, loss of time, loss of members, loss of sight, and medical expenses. Loss of life generally is the province of life insurance; it is covered in health-insurance contracts only in the form of accidental loss of life. Loss of time means total or partial inability to work. The magnitude of the loss of time can be estimated in the same manner as the loss of future income caused by death. Such an analysis would reveal, for example, that the magnitude of the loss caused by total and permanent disability exceeds the loss caused by death because the cost of feeding, clothing, and otherwise maintaining the insured cannot be deducted. Loss of members may or may not include loss of use of members without severance. Medical expenses are those incurred for medical care of various types, such as hospitalization, surgery, nonsurgical treatment by a physician, and nursing care.

THREE IMPORTANT CHARACTERISTICS

Three important characteristics of health insurance are that (1) health-insurance contracts are commonly not contracts of indemnity, (2) the benefits provided with respect to accidental injuries are much more liberal than those paid in case of sickness, and (3) the contract is subject to certain statutory standard provisions.

Relationship to Concept of Indemnity

The health-insurance contract is not, in most cases, a contract of indemnity. A contract of indemnity may not be enforced beyond the payment of financial loss incurred by the insured. Contracts covering loss of wages or other income regularly provide for payment of fixed amounts on evidence that the insured is in a specified physical condition or has incurred certain injuries.

Payments may be even doubled if the insured is injured under certain unusual circumstances. Medical-expense contracts sometimes provide for the payment of stated dollar amounts if the insured is hospitalized or has been the subject of certain surgical operations. Usually, however, under these contracts the insured is paid, on an indemnity basis, the expense of routine medical care, or of surgical operations not covered for specified amounts. Two other features of an indemnity contract are also usually lacking in health-insurance contracts—(1) provisions designed to prevent duplicate recoveries under insurance contracts and (2) subrogation rights. However, because of increasing concern over duplicate recoveries from insurers and from third-party tort-feasors, these two features are becoming an increasingly common characteristic of health insurance, thus bringing it closer to the concept of indemnity.[1]

Accidental-injury Benefits More Liberal than Sickness Benefits

Accident insurance and sickness insurance are often written under separate contracts, and even when both accidents and sickness are covered under one contract, the benefits are usually different. Accident contracts are written freely and without accompanying sickness contracts, but sickness insurance is seldom written except as an accompaniment to accident insurance, and then after much more careful scrutiny. An accidental injury and its results in terms of disability, loss of members, loss of sight, or death, are more definite than is sickness, which may be wholly or partially psychological. It follows that the moral hazard is more active in the claimed occurrence, continuance, or severity of sickness. Further, susceptibility to disease is a less identifiable and ratable characteristic of a human being than is the accident hazard of his occupation or other activities. Finally, accident insurance is easier to sell; a prospect is impressed with the danger of accidental injury, and the premium seems "reasonable." While there is much greater probability of loss from sickness, it does not come home to him, and the same benefits as for accidental injury would entail a much higher premium.

Uniform Policy Provisions Law

In June, 1950, the National Association of Insurance Commissioners adopted the Uniform Individual Accident and Sickness Policy Provisions Law, prepared by its Accident and Health Committee in cooperation with a committee representing disability insurers, and recommended it for enactment in the various

[1] See pp. 109–114.

states. Their purpose was to draft a law which would require contract provisions fair to the insured while properly protecting the insurer, and which would reduce uncertainty as to the terms of the contract by promoting clarity and uniformity. Not only is the language of a large part of the contract specified, but its required form, style, and type size are set forth. However, provisions of different wording are permitted, with the approval of the insurance commissioner, if they are "not less favorable in any respect to the insured or the beneficiary." Certain provisions are optional with the insurer, but their language is specified, if any provisions respecting their subject matter are included in the contract. This law was to apply to contracts covering individuals as distinguished from those covering groups. All jurisdictions have acted favorably upon this law or a closely related version. In December, 1963, the National Association of Insurance Commissioners adopted a report recommending some important changes in the treatment of duplicate insurance. Most states have accepted these revisions.

The most important uniform provisions will be discussed on pp. 336–340. It should be noted here, however, that these provisions do not cover such important matters as the definition of accidental injury, sickness, or disability and the types of benefit they provide. Indeed, health-insurance contracts are noted for their diversity with respect to these matters.

MAJOR CONTRACT PROVISIONS

Health-insurance contracts are written on a wide variety of policy forms, and many discontinued forms are still outstanding. Their principal differences are in benefits offered and in types of accident or disease covered, and there are many other variations in detail that may well concern a prospective insured. It is particularly important to distinguish between significant provisions that meet the risk needs of the insured and provisions that are more in the nature of sales devices.

The Application

Health-insurance contracts are generally issued on receipt of an application signed by the insured, a photostat of which is attached to, and made a part of, the contract. The application consists of a series of questions, with replies by the insured, designed to give the insurer the information necessary to identify the insured, determine the premium, judge the acceptability of the risk, and decide the terms of the contract. They have to do with such matters as age, build, residence, occupation, earnings, other disability insurance, con-

templated hazardous activities, previous insurance claim experience, and health (both present and past).[2]

Entirety of the Contract

"This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance." This provision prevents the insurer from making any oral statements of the insured or, by reference, such documents as its by-laws a part of the contract. Rates or classifications of risks filed with the state insurance department may be incorporated in the contract by reference.[3] The insured has, in the policy, the entire contract.

Accident and Sickness

Defined. Because of the limitation of death coverage to accidental death, and the variations between benefits for accidental injury and those for sickness, definitions of these or similar terms are necessary.

The two principal phrases designating the basis for payment of accident benefits are "accidental bodily injury" and "bodily injuries effected solely through accidental means."[4] While most courts consider these two phrases to have the same meaning, others make a distinction. The distinction is that an accidental bodily injury is one that is unexpected and fortuitous, while an injury by accidental means is one the *cause* of which was unexpected and fortuitous. Applying this distinction, if a man intentionally lifts a heavy weight and strains his back, he incurs an accidental bodily injury, but the injury does not result from accidental means. Consequently the former phrase could be argued to afford broader coverage than the latter. Fortunately for insureds, the latter term is seldom used at the present time.

The words "illness," "sickness," and "disease," used in designating the causes of disability for which benefits will be paid under sickness insurance contracts, do not give rise to questions of definition so much as to questions of fact—whether a given disability results from accident or sickness; whether an insured is actually sick.

A contract covering both accidental bodily injury and sickness covers all causes of disability except self-inflicted injuries and specifically excluded losses.

[2] Ordinarily, a physical examination is required only for long-term noncancellable disability-income contracts.

[3] See pp. 338–339, Change of Occupation, and p. 339, Misstatement of Age.

[4] The words "violent" and "external" have been used further to qualify "means," but they have practically disappeared from contracts currently written.

Total Disability. Total disability is typically defined as complete inability of the insured to engage in his regular occupation. This definition is often applicable for a specified number of weeks of disability, such as 104, after which a stricter definition becomes effective. At one time this more strict definition required the insured to be unable to engage in any occupation or employment for wage or profit. Some courts, however, applied the criteria of the first definition to the wording of the second; in other words, they practically wiped out the distinction. And probably in no case was an extreme interpretation given to the second definition; some test of compatibility of possible work with the age and previous position of the insured would be applied. In many cases application of the two definitions would produce a clear-cut difference in results; a violinist who had lost two fingers of his left hand would be totally disabled under the first definition, but after a short period would be only slightly disabled under the second. Insurers have generally followed the court, by defining total disability during the second period as inability to engage in any occupation or employment for which the insured is qualified or becomes qualified by reason of his education, training, or experience.

Partial Disability. The insured is considered to be partially disabled if he can perform one or more but not all of the duties of his occupation.

Benefits

It is in benefits that one finds extreme and important variations among contracts. It behooves the prospective insured carefully to study the rates of benefit and the limitations, and to distinguish between those that are vital to adequate coverage and those that are of the fringe or selling-point variety.

Some contracts provide only for income in case of disability, others for a variety of benefits. Some are written for a basic rate of benefit, but may be written for multiples of that rate. Some specify what combination of benefits is purchased by a given premium; others (schedule policies) permit the insured to choose the types of benefit and the amounts of each, omitting such as he does not want—all, of course, in accordance with the rules and judgment of the insurer.

Because of these variations, it is not possible to present a statement of benefits that are more than approximately typical of contracts rather widely sold. There is intense competition in this branch of insurance, and competition centers on benefits. The illustrations given below will serve more to indicate what sort of coverage is written than to suggest what combination of bene-

fits is desirable. The analysis is based upon contracts that emphasize disability-income benefits and that are renewable each year only at the option of the insurer. The special nature of contracts that guarantee the right of the insured to continue the protection to some advanced age or that provide only medical-expense protection are described on pp. 340–346.

Accident Benefits

Disability. The benefits payable under the composite contract here used as an example are based on $100 weekly "indemnity" and $20,000 payable for accidental death.

If accidental bodily injury, *commencing within 90 days* of the date of accident, wholly and *continuously* disables the insured, he is entitled to $100 weekly during the period of total disability, total disability being defined less strictly for 104 weeks and more strictly after 104 weeks. If the injury, within 90 days or immediately following a period of total disability, partially and continuously disables the insured, $50 is payable for a period not to exceed 26 *consecutive* weeks. If no disability is incurred within the specified 90 days, no weekly benefit is payable. The reason for this provision is that the relationship between the disability and the accident becomes more doubtful with the passage of time.

Death, Dismemberment, or Loss of Sight. If the insured is entitled to benefits for total disability, and during the period of such entitlement but within 200 weeks after the date of accident, or within 90 days irrespective of total disability, his injury results in loss of life, loss of two major members, loss of sight, or the loss of one eye and one major member, the insurer will pay $20,000. Half this amount is paid if the insured loses one hand, one foot, or the sight of one eye. In this contract these benefits are paid in addition to the total-disability benefits, but in many contracts much less liberal provisions apply. For example, the contract may require the insured to accept these benefits in place of total-disability benefits. If his disability period is a lengthy one, this could work to his disadvantage.

Double Indemnity. Any of these benefits to which the insured or his beneficiary is entitled will be doubled if the injuries are sustained

1 while a passenger in or upon a public conveyance, other than aircraft, provided by a common carrier for passenger service (including the platform, steps or running board of such conveyance);

2 while a passenger in an elevator car provided for passenger service, other than an elevator car in a mine; or are caused
3 by collapse of the outer walls or the burning of a building if the insured is therein at the time of the collapse or commencement of the fire;
4 by the explosion of a steam boiler;
5 by a hurricane or tornado; or
6 by a stroke of lightning.

There appears to be no justification for this provision other than its contribution to the salability of the policy. The person's need for protection is not a function of the nature of the accident.

Medical Care. If the insured requires, commencing within 26 weeks after the date of accident, treatment by a physician or surgeon, hospital confinement, or the employment of a trained nurse, the insurer will pay the expense of such care up to a maximum of $2,000. Most medical-expense insurance, however, is provided under the separate medical-expense-insurance contracts discussed later in this chapter.

Sickness Benefits

Disability. Under the sickness contract a weekly benefit of $100 is payable to the insured during continuous total disability (broader definition) resulting from disease, beginning with the 15th day of disability, to a maximum of 104 consecutive weeks, but only if the disability results from a disease for which the insured is treated by a physician.[5] Longer maximum-benefit periods can be purchased, but, unlike the situation in accident insurance, lifetime benefits are rare. Benefits to age 65 are becoming increasingly common. Shorter or longer waiting periods are also available. Waiting periods are a more common feature of sickness contracts than of accident contracts because of the relatively greater importance of short-term disabilities associated with sickness. Partial disability benefits are almost never written. Despite these limitations, sickness insurance is much more expensive than accident insurance because sickness is a much more common cause of disability.

Hospital and Nursing. If by reason of disease the insured is confined in a hospital or is necessarily attended by a graduate nurse, while the sickness con-

[5] A distinction is sometimes made between *confining* (requiring confinement indoors) and *nonconfining* disability, a lower benefit being payable in respect of the latter.

tract is in force or while benefits are payable for disability under it, the insurer will pay $50 weekly while the insured is in the hospital or while so attended full-time, but not more than 20 weeks for either or both, in addition to any other benefits. Medical expense insurance, however, is most often provided under a separate contract.

Surgical Benefits. If as a result of a disease covered by the contract the insured undergoes a surgical operation while the contract is in force, while any of the previous benefits is payable, or within 90 days after the end of the policy term and during a period of total disability which commenced while the policy was in force, the insurer will pay the amount specified for each operation, in addition to any other benefits, but not more than one amount in respect of any one illness. For example, the contract may provide $300 for cutting into the abdominal cavity for diagnosis or treatment of the organs therein and $75 for the removal of a malignant skin tumor.

Selection of Benefits by Insured

The insured may contract for a weekly benefit up to whatever amount is acceptable to the insurer. All other benefits, with the exception of the death benefit and the maximum medical-care benefit under the accident contract, the amounts of which are separately specified, are increased in the same proportion as the weekly benefit. In fact, these other benefits, which are here stated in dollars, are, in the contract, often stated in multiples or percentages of the weekly benefit.

Exclusions

Exclusions vary, but it is usual to exclude from the coverage of accident contracts losses caused or contributed to by hernia; by disease or infection, except pyogenic (pus-forming) infection from an accidental cut or wound; by war or any act of war or suffered by the insured while in the military or naval service of any country at war (premium is returned pro rata for any period of such service); or by suicide (sane or insane) or any attempt thereat. Excluded losses resulting from aviation usually do not include those incurred while a passenger in an aircraft operated on a regularly scheduled trip over an established route by a passenger airline. The sickness contract excludes losses caused by disability commencing or disease contracted within 14 days from the inception date of the contract;[6] by disease contracted during, or while

[6] This exclusion does not apply to renewals.

engaged in, the military or naval service of any country at war (with return of premium as under the accident contract), or occasioned thereby; or by accidental bodily injury.

Exclusions may be added by endorsement to provide for a waiting period, or a longer waiting period, before payment of benefits, with consequent reduction in premium; to eliminate losses resulting from a specified cause, often a recurrence of a disease from which the insured has suffered, or a specified accident hazard.

Uniform Provisions

While complete uniformity of the general provisions of disability contracts has not been attained, the wide acceptance of the uniform-provisions law has resulted in a considerable degree of uniformity. The following explanation of certain of these provisions is based on that law. Only provisions that are peculiarly characteristic of the disability-insurance contract are considered. The insurer is permitted to use more liberal wording.

Time Limit on Defenses. The provision for a time limit on certain defenses now included in the uniform law follows:

> (a) After three years[7] from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three year period. (b) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

This provision eliminates the uncertainty of past events or conditions being used to deny coverage, unless they are specifically mentioned in the contract or were deliberately misrepresented by the insured.[8]

Grace Period. The following provision is in conformity with the law if included in an annual-premium contract under which the insurer retains the right to

[7] Two years in several states.

[8] Since the disability contract is typically written for a 1-year term, this provision would apply only after inception of the third renewal.

cancel the contract or to refuse to renew it. There are slight variations for other types of contract.

> Unless not less than five days[9] prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted, a grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

Reinstatement. There is considerable danger of adverse selection by the insured in his determination whether to continue a contract in force. Particularly if he has failed to pay the premium on time, he may desire to reinstate the contract in order to cover an event that has happened or that threatens. Hence the following provision for the protection of the insurer:

> If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Claims. Provisions concerning notice of claim, claim forms, proofs of loss, time of payment of claims, payees of claims, and limitations on the insured's

[9] Thirty days in some states.

right to bring legal actions are drawn to fit them to the needs of disability insurance—they are not different in essence from those common to most insurance contracts.[10] However, the insured should check these provisions in order to protect his rights by complying with those which are applicable to him, and to learn what he may require of the insurer.

Physical Examinations and Autopsy. The following provision explains itself:

> The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Change of Beneficiary. The following provision is applicable only to contracts providing for payments to a beneficiary other than the insured:

> Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

The first clause, preceding the words "the right," may be omitted.

Change of Occupation. The preceding uniform provisions must be included in the contract, but a provision concerning change of occupation is optional with the insurer.[11] The first and most important part of the provision follows:

> If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to

[10] See pp. 150–154.

[11] This and the further provisions discussed under "Uniform Provisions" are optional, but if included must be in the language of the law, or in language not less favorable in any respect to the insured or the beneficiary.

> one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent.

This provision protects the insurer against incurring risk greater than was contemplated in determining the premium, and the insured from paying a premium greater than appropriate to the risk.

Misstatement of Age. The insurer may include a provision that if the age of the insured has been misstated, all amounts payable shall be what the premium paid would have purchased at the correct age.

Other Insurance. Disability insurers attempt to keep the benefits payable well within the amounts that might make the insured indifferent or even adverse to recovery from disability or inclined to make undue use of hospital or other care. An insurer may rely on questions in the application or on investigation, but may also provide for limitation of coverage or of benefits payable by inserting provisions in the contract that apply to other insurance with the same insurer or with other insurers. With the rapid growth and liberalization of employee-benefit plans and the increasing number of working wives, over-insurance has become a much more important problem in recent years and insurers increasingly include provisions dealing with other insurance in their contracts.[12] For example, under the 1963 amendments to the uniform laws, an insurer may reduce benefits by reason of overinsurance after benefits have been paid for 90 days. If the total benefits from all valid loss-of-time insurance exceeds 60 per cent (reduced from 100 per cent because of tax and other savings) of the insured's monthly earnings at the time the disability commences (or, if higher, his average monthly wage during the two preceding years), the insurer is responsible only for its pro-rata share (its benefit divided by the total benefits) of 60 per cent of the earnings loss. However, this provision is not permitted to reduce the total combined benefits to less than $300. A similar pro-rata scheme may apply to medical expenses in excess of some specified amount. An insured should learn whether such provisions are included, and if so, what effect they would have on any claim he might make.

[12] For a statement of the problem and its possible solution see William H. Wandel, "Overinsurance in Health Insurance."

Cancellation. The contract may include a provision that the insurer may cancel the contract

> *at any time* by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter [*i.e.*, after delivery or mailing], such cancellation shall be effective . . . [emphasis supplied].

The insured may cancel at any time after the contract has been continued *beyond its original term.* Cancellation will not affect the insurer's liability as to any claim originating prior to the effective date of cancellation. Sometimes the insurer agrees that it must state certain reasons other than the deterioration of the insured's health for the refusal to renew. Several states prohibit cancellation during each 1-year policy period.

Other Optional Provisions. The contract may contain a provision that due and unpaid premiums may be deducted from claim payments; that any provision in conflict with a state statute is amended to conform to it; that the insurer shall not be liable for a loss to which a contributing cause was the insured's commission of, or attempt to commit, a felony, or engagement in an illegal occupation; that the insurer shall not be liable for any loss caused by the insured being intoxicated or under the influence of a narcotic unless administered on the advice of a physician.

Noncancellable and Guaranteed Renewable Insurance

While the term *noncancellable* has sometimes been improperly used to describe a 1-year contract without a cancellation clause, it generally means not only that the contract may not be canceled but that the insured has the option of continuing it from year to year, up to a stated age, by timely payment of a specified premium. The limiting age is usually 60 or 65, but may be 70 under a loss-of-income accident contract.

The National Association of Insurance Commissioners recommends the following ruling:

> The terms "non-cancellable" or "non-cancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

Some insurers have become chary of guaranteeing premium rates for a long period particularly for contracts covering the cost of medical care. The NAIC recommends permitting the use of the term *"guaranteed renewable,"* but not "non-cancellable," only in a policy of the type described above . . . "except that the insurer may make changes in premium rates by classes." Coverage may not be changed during the period of the contract, and an individual's premium rate may be changed only in accordance with a revision of rates for the class to which he belongs.

Thus a noncancellable contract is one whose renewability and cost are guaranteed, subject only to the condition that the premium be paid on time, while one that is guaranteed renewable may be subject to the payment of a fluctuating cost.

The noncancellable contract "insures the insurance." Other contracts may be canceled, or renewals refused, where the insurer feels that the insured has deteriorated as a disability risk or where new information suggests the desirability of such action. Because the insurer commits itself, under the noncancellable form, to cover the insured for a considerable period, a searching medical examination, check on amount and stability of income, and general inquiry are required before accepting an application; this is usually stricter than for life insurance.

Certain provisions, discussed below, are characteristic of, or peculiar to, this type of disability insurance. Although not listed below, it should be apparent why the relation of earnings to insurance provision discussed on p. 339 is a more common feature of this insurance than of cancellable insurance.

Incontestable Clause. A noncancellable contract may substitute, under the uniform law, under the caption "Incontestable Clause," the following provision in lieu of provision (a) under "Time Limit on Certain Defenses":[13]

> After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

The clause in parenthesis may be omitted.

Recurrent Disability. Frequently found in noncancellable contracts is a provision that if, following a period of disability, the insured resumes his regular occupation for 6 months or more, any subsequent disability will be deemed a

[13] See p. 336.

new period of disability; if for less than 6 months, subsequent disability *from the same cause* will be deemed a continuance of the former disability.

Benefit Limits. During the period of general optimism in the 1920's extremely liberal noncancellable contracts were written with provision for payment of benefits for disability of any length. The experience of insurers under these contracts was bad, many incurring large underwriting losses and at least two being forced into reorganization. As a consequence most contracts now place a limit on the benefit period for each disability for which benefits will be payable if the disability is caused by sickness. Short-term contracts provide benefits for 3 years or less; intermediate contracts for about 10 years; and extra-long-term contracts for 15 years or, most commonly, to age 65. Long-term contracts usually provide only a total-disability-income benefit.

Deductible. The deductible principle is generally applied in noncancellable contracts, at least in respect of the sickness coverage. Deductibles (elimination periods or waiting periods) vary from 7 to 90 days (rarely 6 months or 1 year), with commensurate adjustments in premium. For a given premium the insured may secure larger benefits for the more serious disabilities.

Waiver of Premium. Most noncancellable contracts provide for waiver of premiums during a period of disability for which benefits are payable and after disability has continued for a specified period: 3 months, 4 months, 6 months, or even a year.

Medical Expense Insurance

There has been extensive development of medical care insurance during recent years, both by insurers writing a broad line of disability insurance and by insurers organized specifically to provide medical care.

Disability Insurers. Contracts for medical care offered by insurers writing general disability insurance are in the form of clauses in disability contracts, endorsements to disability contracts, and separate policies. The separate policies are the most important in terms of persons covered. Like disability income insurance, these separate contracts are written on a cancellable, or guaranteed-renewable, basis. Cancellable insurance is the most common.

Medical-expense contracts can also be classified according to whether they

are basic, major-medical, or comprehensive contracts. *Basic medical expense insurance* is designed to enable the insured to budget systematically the medical expenses associated with the less costly illnesses. These contracts usually cover hospital-room-and-board charges up to a specified amount (say $15) for a specified period (say 100 days), the cost of hospital services other than room and board (X-rays, operating room, laboratory tests, etc.) up to some specified amount (say 30 times the daily room-and-board allowance); surgical fees according to a schedule that varies the allowance according to the nature of the operations; and charges for nonsurgical care by a physician in the hospital or, less commonly, in the doctor's office or the patient's home. These physicians' charges are usually limited to, say, a stated amount per visit (say $4–6 per visit) and some aggregate amount (such as $250).

A much more recent (since the late 1940's) addition to medical-care contracts is *major medical expense insurance,* which covers major expenses for medical care of most kinds. Under this contract, the insurer pays a percentage of such medical expenses (as defined in the contract) for any one accidental injury or illness as exceed a specified deductible. An insurer may pay 75 or 80 per cent of expenses in excess of $100, $500, or $1,000 up to a maximum of $10,000 or $20,000, or even more in benefits. They are written to cover individuals or families.[14]

The basic characteristics of this form of contract are the *blanket coverage,* the *deductible,* the *percentage participation,* and the *maximum amount.* Although some major-medical-expense contracts do contain internal limits with respect to daily hospital-room-and-board charges and surgical fees, hospitalization is not required and, for the most part, because of blanket protection, the insured's claim does not depend upon the mixture of the covered services he requires. In other words, his recovery will be the same whether it includes $1500 in hospital bills and $500 in surgical fees or $1800 in private-nursing fees and $200 in drug expense. By eliminating small claims and the expense of handling them, the deductible enables the insurer to offer broad coverage of serious losses in large amounts; the percentage participation, by giving the insured an interest in limiting expenses, tends to lessen overutilization of medical services; the maximum amount keeps the premium and the insurer's possible loss within bounds.

This insurance has the great virtue of enabling an insured to protect himself against really serious losses for a premium that is not burdensome.

Comprehensive medical expense insurance is a hybrid of basic and major medical expense insurance. Two forms are common. One is essentially a

[14] The 20 or 25 per cent borne by the insured is often called a *coinsurance* percentage. While coinsurance is an arrangement under which more than one party bears a loss, its very different application in fire and allied lines is likely to cause confusion to insureds. The term "percentage participation" will be used in this text.

major-medical-expense-insurance contract with a small deductible. The second may provide basic-hospitalization and surgical-expense protection up to some specified amount such as $500. The other types of expense are subject to a deductible, and the insurer pays a stated percentage of those medical expenses not excluded by the deductible or covered by the basic element. This insurance, which has proved to be extremely popular, thus provides some protection against both the minor and the major losses at a higher, though still reasonable, cost compared with major medical expense insurance.

Blue Cross. Blue Cross plans are another important source of medical-expense protection. A Blue Cross association is a voluntary nonprofit hospital-expense-prepayment plan that has applied for and received the approval of the American Hospital Association and the Blue Cross Association. There are about 80 such local independent plans in the United States. The promoters of most associations are the hospitals in the plan area, but the boards of directors usually include representatives of hospitals, the medical professions, and the public.

Blue Cross plans offer hospital-care contracts to individuals who are not members of a group as well as to those who are. The benefits vary greatly even within the same plan and may be in the form of service or cash payments to hospitals toward the cost of service. Under service contracts, which the plans favor, the service provided is usually room and board (regardless of the charge in the particular hospital), general nursing service, use of the operating room, and a broad list of other services in ward or semiprivate accommodations of member hospitals for, say, 70 or 180 days per illness. Subscribers preferring private accommodations or the services of a nonmember hospital receive a stated dollar allowance. Variations are found in the number of days of hospital confinement covered, in the amount or character of benefits, in provision of partial benefits after a period of full benefits, in extra hospital services, in coverage of maternity, in exclusion or limitation of benefits for stated diseases, and in periods from inception of the contract during which benefits will not be paid in respect of preexisting conditions, tonsillitis, diseased adenoids, maternity, or appendicitis. Reciprocal agreements among the plans provide a mechanism for providing continuous coverage when a subscriber moves to a different-plan area or is hospitalized outside his own area. Some plans, usually operating in conjunction with a Blue Shield plan, offer the equivalent of comprehensive medical expense insurance.

Blue Shield. Blue Shield plans are voluntary nonprofit prepayment plans covering surgical fees and charges for physicians' care that have applied for

and qualified for membership in the National Association of Blue Shield Plans. There are about 85 Blue Shield plans in the United States. The sponsor of the plan is usually a local medical society.

Most Blue Shield contracts are sold to members of eligible groups, but individual contracts are also common. Different plans issue different contracts, but they all cover at least charges for surgical services and for nonsurgical physicians' care in a hospital. Most contracts provide that if the subscribers' income is less than a stated amount (say $4,000 for single subscribers and $6,000 for family subscribers), participating physicians will accept the plan benefit as full payment for their services. If the subscriber's income exceeds the stated amount, the plan benefit is deducted from the physicians' charge. Unlike the Blue Cross plans, therefore, Blue Shield service benefits depend upon the subscriber's income. However, an increasing number of plans provide service benefits for all subsidiaries as long as the doctor's charges are "usual and customary." Like Blue Cross plans, the Blue Shield plans have some important reciprocal agreements.

Independent Plans. Independent plans include all plans other than those underwritten by the "commercial" disability insurers, Blue Cross plans, or Blue Shield plans. At the close of 1964 there were about 580 such plans in the United States providing round-the-clock coverage throughout the year.[15] These plans include (1) community-consumer plans operated by representatives of, and for the service of, the general community or a particular consumer group, (2) industrial plans, usually operated by jointly managed (employer-union) welfare funds, (3) non-Blue Shield medical-society plans, (4) private-group clinics of physicians or dentists, and (5) dental-society plans. Two distinctive features of these plans are that (1) many of them provide benefits, such as annual physical examinations and periodic eye examinations, that are not covered by the more traditional plans and (2) many of them provide the medical service itself through their facilities and salaried staff or through a contractual arrangement with a community hospital or a group-practice clinic owned or operated by private physicians. Thus, although only

[15] Excluded from this total are student-health service and similar programs that provide coverage for part of the day or year. For a recent comprehensive survey, see L. S. Reed, A. H. Anderson, and R. S. Hanft, "Independent Health Insurance Plans in the United States: 1965 Survey," *Research Report No. 17*, U. S. Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, 1966. For more recent information on enrollment, income, and expenses, see "Independent Health Insurance Plans in 1967," *Research and Statistics Note No. 16*, U. S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, Aug. 22, 1968.

about 7 per cent of the persons with health insurance belong to some independent plan, the role of these plans as experimenters makes them an important part of the total health-insurance scene.

Medical Expense Insurance for the Aged. As will be indicated in Chapter 37, in 1965 the Social Security Act was amended to provide medical expense insurance for the aged in the form of Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). All types of private insurers have developed contracts to supplement the government program. For example, the "commercial" insurers and the "Blues" have contracts under which the insurer will contribute (1) to the cost of certain types of services that are not included under the public programs or (2) the cost of covered types of services whose entire cost is not included under HI or SMI.

Industrial Insurance

Among the low-income groups of metropolitan manufacturing areas and of the Southeastern states contracts providing small benefits at low weekly-premium rates are sold. They are written largely by insurers specializing in this type of business.

Limited Contracts

The Official Guide of the National Association of Insurance Commissioners defines a limited contract (or policy) as "one that contains unusual exclusions, limitations, reductions, or conditions of such a restrictive nature that the payment of benefits under such policy are [*sic*] limited in frequency or in amounts."

Characteristic of these contracts are limitations on covered causes of injury or sickness—the causes covered are usually specifically named. To protect insureds who might not understand the nature of the contract, the insurer is required, where *The Official Guide* is followed, to have imprinted diagonally across the face of the contract and the filing back the words "THIS IS A LIMITED POLICY—READ IT CAREFULLY." This statement must be in outline type not smaller than 18-point and printed in a color contrasting with the text of the contract. The words may be varied to indicate the type of contract, e.g., "THIS POLICY IS LIMITED TO AUTOMOTIVE ACCIDENTS—READ IT CAREFULLY."

Some examples will illustrate the nature of these contracts. A few insurers offer *polio-insurance* contracts covering, up to an aggregate amount, medical expenses of all kinds, including those for necessary therapeutic and prosthetic

devices, incurred by the insured as a result of poliomyelitis. The aggregate limits and the expenses covered vary somewhat between insurers. *Dread-disease contracts* cover expenses of the same general extent as do polio contracts, but resulting from such disease as encephalitis, diphtheria, tetanus, scarlet fever, and spinal meningitis, as specified in the contract. Limited insurance is sometimes written as a bonus to be offered to subscribers to newspapers.

Contracts of accident insurance covering the insured for a limited period of time are sold at railroad ticket windows and at airports. They are also written to cover vacation trips or participation in sports.

Disability insurance has had a rapid development in recent years and the insuring public is offered comprehensive and liberal contracts. But it is still true that many insureds do not understand the limitations in their contracts, even though insurers and state insurance departments have eliminated many of the objectionable practices of the old days. It is still impossible to cover in full loss of income and extra expense due to disability, and it probably always will be. To reconcile the need for broad coverage, the willingness of buyers to pay premiums, the tendency to exaggerate claims, varying degrees of insurability, selling methods, and the urge to make profits on the business is a considerable problem in a branch of insurance where human nature is constantly demonstrating its good and bad qualities.

QUESTIONS

1 Distinguish between "accidental bodily injury" and "bodily injury effected solely through accidental means." What is the practical significance of this distinction?

2 As a result of an accident that occurred on Feb. 1, 1968, an insured under a typical accident-insurance contract becomes totally disabled on May 20. His total disability continues until June 5, when his condition improves, but he is partially disabled until June 17. On July 1, still due to the accident, he is again totally disabled until July 15, when his disability ends. For what periods would he receive "indemnity" for total disability? For partial disability?

3 An insured states in his application that he has not taken medical advice during the past 5 years or account of any departure from good health, concealing the fact that he had been treated for jaundice during that time. The 1-year contract is renewed 3 times. Shortly after the third renewal he makes a claim for disability "indemnity" which, after investigation by the insurer and discovery of the concealment, is denied. Is the denial justified by the terms of the contract?

4 An insured under an accident-insurance contract makes a claim after having changed his occupation to one less hazardous than that which he was following at the time of effecting the insurance, notice of the change having reached the insurer previously to the making of the claim. The premium paid was $32 for a 1-year contract; the premium for a contract at the new occupation is $24. What effect will the change have on the amount paid by the insurer?

5 Jones argues that life- and health-insurance contracts are alike in that neither of them are contracts of indemnity. Discuss.

6 Contrast the benefits available with respect to accidental injuries with those available with respect to sickness. Why do they differ?

7 Would you prefer a cancellable, noncancellable, or guaranteed-renewable health-insurance contract? Why?

8 With a given limited amount available to pay for medical care insurance, would you purchase a contract providing payment of expenses from the beginning, one with a small (say $25) deductible, or one of the major-medical-expense type? Why?

9 In what sense do Blue Cross and Blue Shield plans provide "service" benefits?

10 Why are independent plans an important factor in health insurance?

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GROUP INSURANCE AND PENSION PLANS

Group insurance is insurance of a group of employees of a common employer under a contract between the employer and an insurer.[1] The employer is responsible for the payment of premiums, for much of the accounting, for submission of claim papers, and for other incidental services. Each insured employee is notified of his rights and obligations (and those of his dependents or beneficiaries) under the contract by booklets and certificates.[2]

The insurer determines the acceptability of the *group* for insurance, and all employees eligible under the terms of the contract usually will, or may be, insured without regard to their individual insurability.

The group-insurance field is highly competitive, and each group, particularly if it is large, is an individual problem. The character of the group, its industrial classification, the financial resources of the employer, his attitude, type of employee, distribution of employees by age, area, length of service, and sex, pressure from employees, the underwriting policy of the insurer, comparative costs between insurers, industry practice, and statutes—all have their influence on the terms of the contract. So varied are the results that, in a brief chapter, one can only deal with the general nature and kinds of group insurance, explain some of the problems, and present examples of how it is used.

It should be understood that many general statements made in this chapter are subject to qualifications. In considering any particular group-insurance problem they might well be taken only as points of departure. Carefully to indicate every possibility of variation from the general rule would needlessly complicate the exposition and would probably present a distorted picture of the purposes and methods of this type of insurance.

[1] Group insurance is also written on certain other types of group. See pp. 366–367.

[2] The reader should obtain one or more of these booklets and read them in conjunction with this chapter.

KINDS OF INSURANCE

For several years after its origin in 1912, only life insurance was written under group contracts. Now the field of group insurance comprises life, health, accidental death and dismemberment, medical expense (hospital, surgical, nonsurgical physicians' care, major medical, nursing, and special services), and annuities. In the jargon of the business a distinction is made between "insurance" and "annuities," but basically both life insurance and annuities are *insurance* and will be so treated here.

Most group insurance is issued in connection with an employee-benefit plan, but not all employee-benefit plans utilize group-insurance contracts. Some employers prefer to self-insure the plan benefits or there is a jointly managed (employer-union) welfare fund that underwrites its own benefits. These self-insurance benefits are most important in the pension field with over two-thirds of the covered employees belonging to a self-insured plan. Consequently, brief mention of the unique characteristics of self-insured pension plans will be made in the section on pensions in this chapter. Self-insurance is considerably less important, but still important, in the other benefit areas. The industrial medical-expense plans, the most significant of these other self-insured arrangements, have already been described briefly on pp. 345–346.

The importance of these employee-benefit plans is illustrated by the data on their coverage and their annual costs presented in Table 23–1. Each of the types of benefit is described in the remainder of this chapter.

GENERAL CHARACTERISTICS

The two outstanding advantages of group insurance are that it provides savings in expense of operation and enables employees to secure insurance not otherwise available to them.

Savings in expense are due primarily to centralization of negotiation and administration of the insurance of each group. Payment of premiums, accounting, and various other services are handled with the employer. Further, commissions on the sale of group insurance are low percentagewise and are paid on a sliding scale which provides for a decrease in percentage as the size of group, measured in premiums, increases.

Employees who are otherwise uninsurable may be covered under a group contract because the group is underwritten (i.e., its insurability is judged and the terms of the contract, including rates, fixed) as a unit.

The insurer is concerned with average results for the group and can accept the poorer-than-average individual risk if the group as a whole is acceptable.

Table 23–1 ESTIMATED COVERAGE OF WAGE AND SALARY WORKERS AND THEIR DEPENDENTS UNDER EMPLOYEE-BENEFIT PLANS AND TOTAL EMPLOYER AND EMPLOYEE CONTRIBUTIONS, 1966*

(Numbers and amounts in millions)

Type of benefit	Coverage			Contributions	
	Employees				
	Number	Per cent of employed wage and salary workers	Dependents	Amount	Per cent of total wages and salaries
Private and public employees:					
Life-insurance and death benefits	42.6	62.1	6.5	$2,361	0.62
Accidental death and dismemberment	28.5	41.5	. . .	131	0.03
Hospitalization	50.1	73.0	78.1	4,547	1.20
Surgical	48.6	70.8	75.4	2,300	0.61
Nonsurgical physicians' care	41.2	60.0	63.0		
Major-medical expense	19.0	27.7	33.0	1,195	0.31
Private employees only:					
Temporary disability	29.3	51.1	. . .	1,721	0.54
Pension	26.4	46.1	. . .	8,400	2.65
Supplemental unemployment	2.2	3.8	. . .	128	0.04

* Comprises plans whose benefits flow from the employment relationship and are not underwritten or paid directly by government.

Source: Walter W. Kolodrubetz, "Employee-Benefit Plans in 1966," *Social Security Bulletin*, vol. 31, no. 4 (April, 1968), pp. 26–28.

Size of Group

Groups are generally required to consist of at least 10 eligible employees, though groups as small as 4 may be written under disability contracts, and insurers often make a distinction in methods of handling small and large groups, say, those of under 25, and those of 25 or over.

Eligibility

No general statement of rules governing eligibility of employees for enrollment in group plans can properly be made. Each group has its own rules. One general requirement, however, is that eligibility for coverage shall be based on conditions of employment and shall not permit individual selection, which might be adverse to the insurer.

Eligibility is usually based on one or more of the following: period of service, occupation, and wages. Age may also be a factor under annuity plans. If the plan requires the employee to contribute to the cost, he may usually decline to enter the insured group. If he does so decline when he becomes eligible (or during a grace period thereafter), he is usually later permitted to enter the group only on giving evidence of insurability, except in the case of annuities.

Imposing a requirement of a certain period of service (the *probationary period*) may have one or both of two purposes: (1) avoiding the expense of enrolling "floaters" and of handling the details of termination of their insurance, and (2) holding out membership in the group as a reward for continued service.

Automatic Determination of Benefits

Because an eligible group is likely to include persons in various states of health, each individual member cannot be permitted to select the amount of his own benefit. Otherwise the unhealthy lives would select large life- and health-insurance benefits while the healthy lives would choose much smaller amounts of protection. Consequently some yardstick, such as salary or position, is used to determine each member's benefit automatically.[3]

[3] Sometimes a member has some limited choice. For example, a life-insurance plan may provide a benefit equal to 1 year's salary and give the employee the option to double this amount.

Premium Rates

A weighted average premium rate that reflects the composition of the group is quoted at the inception of the insurance and is usually guaranteed for a period of 1 year.[4] The contract provides for adjustment of the rate after the period of guarantee.

Costs

Participating insurers pay dividends based in part on their general experience with group insurance and in part on the experience of the particular group (if it is large enough to have a credible experience). Nonparticipating insurers accomplish the same purpose by retroactive adjustment of premiums. In either case, the cost to the employer reflects the actual cost of insuring his own group, the influence of his experience increasing as the group increases in size.

Occasionally, under plans (other than annuity) providing for contributions from employees, it will be found that the dividend or adjustment exceeds the amount originally contributed by the employer. In such a case the employer must use this excess only for the benefit of the employees under the plan. This may be done by refund to the employees, by reducing or remitting contributions for a period, by increasing the insurance, or by otherwise providing for additional benefits.

Retention

The difference between the premiums charged and the sum of the claims incurred, dividends, and rate credits earned is the insurer's retention. The retention is the amount required by the insurer to (1) meet expenses of operation and (2) make provision for future contingencies and for losses on unprofitable groups.[5]

Accounting

Payment of premiums or annuity considerations is usually on a monthly basis, employers being charged in accordance with the employees covered on the due

[4] Except for annuities, for which rates of payment are commonly guaranteed for purchases made during the first 5 years of the contract and thereafter on a year-to-year basis.

[5] The term "retention" is not used in connection with annuity plans, under which the insurer must make provision for reserves for annuities purchased to become payable at a future date.

date. For larger groups, arrangements are often available under which the employer maintains all the records of insurance in force and prepares the monthly statement of premiums payable. Under this method of accounting, the expense charges by the insurer are lower than would otherwise be the case.

Payroll Deductions

If employees contribute to the payment of premiums, their shares are deducted from wages or salaries after securing formal authorization from each employee.

Contributions

Group plans are *contributory* or *noncontributory*. Under contributory plans, both employer and employee share in payment of the cost of the plan. The employee's share is a fixed amount per unit of coverage. The employee may pay the entire premium cost of disability benefits, or of certain of them, his advantage lying in the convenience of the arrangement, the lower cost of group as compared with individual insurance, and the opportunity to obtain insurance that otherwise might not be available.

If a plan is contributory, each eligible employee must be given the option of enrolling in the plan. For a plan to be put into effect, at least 75 per cent of the eligibles must elect to enroll, and the number enrolling must at least equal the minimum number required for installing the plan. After the plan is in operation these requirements continue, the insurer being free to discontinue coverage at renewal date if the number enrolled falls below the 75 per cent or the minimum. Under noncontributory (or *employer-pay-all*) plans, all eligible employees are automatically covered.

It is usual to require that an employee be actively at work to become insured, except under an annuity plan. In connection with very small groups, some evidence of insurability may also be required.

Whether the plan shall be contributory or noncontributory, and if contributory, to what extent, are among the major problems to be settled in drawing up a group-insurance plan. From the employer's point of view the following considerations are determining: his desire to meet the costs of the plan; his financial resources, present and future; the extent to which tax savings will offset the cost; the effect on employees (will they be more or less well disposed by the adoption of the one plan or the other?); and control of the plan. From the point of view of the employee: if contributory, will his contributions buy more insurance than on an individual basis? Will he have more influence on the plan and its administration? Will the plan be less likely to be discontinued or its benefits reduced? Is he willing to spend the money? Will he be tempted

to forego benefits that he needs or, under an annuity plan, to cash in his contributions? Or will it be to his advantage to have the employer buy with tax-exempt premiums rather than contribute from his own taxed income?

This point is so important that it deserves further explanation. Employer contributions to a group-life or health-insurance program do not constitute taxable income to the employee, but employees cannot deduct their own contribution in determining their federal income tax. Consequently, if an employee's income places him in a 20 per cent marginal tax bracket, an employer would have to pay an employee $125 in wages before he could match net of taxes a $100 direct contribution by the employer. The situation with respect to pension contributions is more complex because the pension made possible by employer contributions is taxed after the employee retires. Generally, however, the same principle holds because most employees will be in a much lower tax bracket at that time. No pat answer to the choice between a contributory and a noncontributory plan can be given, but the trend is toward noncontributory plans. The actual answers must vary between cases and periods.

Collective Bargaining

Group-insurance plans are now generally recognized as a matter for negotiation between employers and workers, and collective bargaining is much concerned with them. Union demands are often for a combination of increased wages and increased insurance benefits, and settlements of disputes may turn on such plans as much as on wage rates.

GROUP LIFE INSURANCE

Group life insurance is generally written as 1-year-renewable-term insurance. "This plan is the most popular since it is simple and its cost is low. It is well adapted to the insurance of employees who form a fluctuating group, since adjustments of premiums on account of new entrants and withdrawals are easily made and there are no accumulated equities to be adjusted."[6]

While the majority of group-life-insurance plans are on the 1-year-renewable-term basis, a substantial volume is also written on various "permanent" plans to meet particular needs. Some forms of level-premium group permanent life insurance, such as retirement income or endowment, are written primarily as a means of funding a pension plan. Other plans provide for a combination of reducing term insurance and annual purchases of units of paid-up insurance

[6] Joseph B. Maclean, "Life Insurance," p. 355.

which the employee may retain on termination of employment or on retirement. Under one type of plan a uniform unit of paid-up whole life insurance is purchased for each employee for each year that he is in a given salary class. Under another type, the employees' contributions are used to buy decreasing units of paid-up insurance each year. Under either plan, the total amount of insurance, term plus paid-up, is fixed according to the schedule of benefits, the difference between the total amount and the accumulated units of paid-up insurance being in the form of term insurance.

Tax considerations govern, in some measure, the type of plan adopted.

Formulas

The *formula*, in group insurance, is the schedule of benefits payable under the contract. In group life insurance, the amount of insurance might be (1) flat, (2) some multiple (generally not greater than two) of the amount of the employee's annual wages, (3) an amount for each of several wage classes, each including a range of wages, (4) an amount for each class of position held, or (5) an amount based on length of service. The third type is most commonly used; it adjusts the insurance to the economic position of the employee both as to amount and, under a contributory plan, ability to pay, and it requires adjustment only when the employee moves from one wage class to another.

Employee's Privilege of Purchasing Individual Insurance

Under the 1-year-renewable-term plan, an insured employee may, upon termination of employment, purchase, within 31 days and without evidence of insurability, a policy on any plan (other than term)[7] written by the insurer, for the amount of his group coverage, at the rate for the new insurance at his attained age. This conversion privilege is important if the terminating employee is uninsurable at that time or if he is insurable only at higher-than-standard rates. A similar privilege is available on termination of a group contract, to employees who have been insured for 5 years or longer, but for not more than the amount terminated less any new or reinstated group insurance effected within 31 days of termination, or $2,000, whichever is less. If an employee dies during the period within which he might have exercised one of these privileges but has not done so, the amount of insurance which he might have obtained is payable as a claim under the group contract. As a matter of practice it is so paid even if he has exercised his privilege, in which event no payment is made under the individual contract.

[7] New York and West Virginia require that the individual policy be available as term insurance for a term of not more than 1 year.

Beneficiary

The employee may name anyone, other than the employer, as beneficiary. If there is no beneficiary named, or the beneficiary has died, the insurer will pay the amount of the insurance to the estate of the employee or may pay it to a relative, such as wife or husband, children, or parents. Many contracts provide that the insurer may pay a specified sum, say $250 or $500, to any person who appears to be equitably entitled to such payment by reason of having incurred expenses on behalf of the insured or for his burial.

Misstatement of Age

Under a group 1-year-term contract, in case of misstatement of age, the premium may be adjusted, but seldom is, since the effect is usually negligible. Under other forms the amount of insurance or the premium may be adjusted.

Suspension of Employment

In case of temporary suspension of employment, the insurance may be continued for a limited period, usually 3 months, if payment of the premium is continued.

Retired Employees

Provision may be made for continuance of group life insurance on retired employees. The employer usually pays the entire cost for continuing the insurance either for the amount in force at retirement or for a reduced amount.

Disability

Provision is often made for the payment of the insurance on death if the employee becomes totally disabled before age 60, while still employed, and such disability continues uninterruptedly to the date of death, provided that evidence of the continuance of such total disability is presented to the insurance company once a year for the entire period of disability.

PENSION PLANS

Provision of pensions at retirement from employment has become an increasingly accepted practice of employers. An adequate pension plan is an advantage in securing and holding personnel.

The beginnings of pensions were unfortunate. Whether they were to be

granted and what their amount would be were often matters for special action in individual cases by boards of directors or trustees. Even where a formal general plan had been adopted, the employee had no contractual right to payment. Advance financial provision for pensions was seldom made, and good intentions often were not carried out because of inability to make the pension payments.

Present-day plans usually are formalized, are to some extent contractual, and are generally characterized by some degree of advance funding.

Formulas

The amount of the pension to be paid may be determined in either of two ways. Under a *defined-contribution plan*, an agreed-upon contribution is paid to the plan, and the pension amounts to whatever it will purchase. For example, an employee might contribute 5 per cent of his salary, to be matched by an equal contribution by his employer, the pension depending on the purchasing power of the total. The contributions might be fixed at other percentages and might be unlevel as between employer and employees. The plan has the appeal of a definite cost in relation to the payroll, but it leaves the amount of the pension uncertain since rates vary from time to time. It is little used except by colleges, universities, and other educational institutions for their academic employees.

The usual arrangement is the *defined-benefit* plan, under which a definite pension is agreed upon, the employer bearing the entire cost or the excess of the cost over employees' contributions. The benefit may be a flat amount for all employees or a specified function of earnings or service, or both.

The usual provision of defined benefits is for a monthly payment for life, commencing on retirement, of a percentage of monthly earnings during employment, multiplied by the number of years at each rate of earnings. For example, assume that 1 per cent of the first $400, and 2 per cent of earnings in excess of $400, are to be paid, and that an employee had earnings of $400 monthly from age 30 (when pension credits commenced to accrue) to age 40, $600 from age 40 to age 50, and $800 from age 50 to age 65 (when he retired). His monthly pension would be calculated as follows:

Age	Monthly earnings		Monthly pension
30–40	$400		$4 \times 10 = $ 40
40–50	600	$400	4 \times 10 = 40
		200	4 \times 10 = 40
50–65	800	$400	4 \times 15 = 60
		400	8 \times 15 = 120
Total monthly pension	. . . . .		$300

Thus his monthly pension would be $300, or 37.5 per cent of his final earnings. An alternative way to state this formula is the number of years of service times 1 per cent of the first $400 of average career earnings plus 2 per cent of the average earnings in excess of $400 or, in this case, 35 times $0.01(\$400) + 0.02(\$228\frac{5}{7}) = \$300$.

Since 50 per cent of final earnings is generally regarded as a reasonable goal, such a formula would, with OASDI benefits, be adequate in this case. In recent years, however, because of rapidly rising wage levels, there has been a trend toward basing pensions on average earnings during the employee's last 5 or 10 years of employment.

Other common defined benefits are illustrated by the following: $5 per month per year of service, 50 per cent of final salary, and $100 per month.

An increasing number of pension plans provide a pension benefit that varies according to changes in the Consumer's Price Index or in the performance of the investment portfolio of the pension fund.[8]

Past-service Benefits

The discussion above of formulas assumes a plan in force during the entire period of the employee's eligibility for crediting of rights to pension benefits. But plans are installed by employers many or most of whose employees have already worked for periods during which such rights would have accrued had the pension plan been in effect. If the new plan is to be fairly applied and is to be generally satisfactory, it must provide for recognition of this past service.

Since it might be difficult or impossible to determine the past-earnings history of each employee, it is customary to relate benefits on account of past service to earnings current at the effective date of the plan. And because an employee's earnings at that time are generally at the maximum for the period of past service, the percentage used to calculate the amount of benefits is usually lower than that used for service after the effective date of the plan. If future-service benefits are to accrue at the rate of 1 per cent of earnings, past-service benefits might be set at ¾ per cent; if future-service benefits are to be graduated, past-service benefits might also be graduated.

OASDI

Retirement benefits are provided by the federal government under Old-Age, Survivors, and Disability Insurance, the most important of several programs established under the Social Security Act.[9] Pension plans generally take these

[8] See pp. 321–322 on variable annuities.
[9] See Chapter 37.

prospective benefits into account by applying a smaller percentage benefit to that portion of an employee's earnings under the maximum amount used in determining OASDI benefits.

Eligibility

Employees usually become eligible for participation in a retirement plan after a specified period of service, which may be as much as 5 years, and attainment of a specified age, say 30.

Retirement Age

The normal retirement age under most pension plans is age 65, the same as the normal retirement age under OASDI. Retirement is usually made compulsory at the normal retirement age in order to avoid the difficult task of determining who should be retired, usually because of failing powers and to make way for the advancement of younger men.

Plans often permit retirement previous to the normal retirement age, sometimes subject to specified conditions, at reduced rates of pension. Early retirement has become a more common phenomena in recent years because reduced OASDI benefits are now available as early as age 62, and rapid technological changes have caused employment problems for many older workers. Provision may also be made to defer retirement beyond the normal retirement age, usually without increase in benefits.

Optional Benefits

Certain options in lieu of straight pension payable only to the worker during his lifetime are often made available to permit the adjustment of income to circumstances *after retirement*. For example, he may arrange to take a smaller income, with an income continuing to his widow or other dependents after his death.

Vesting

Pensions were originally regarded as rewards for long and "loyal" service to a single employer; they are still so regarded in some quarters. But the idea that as a worker earns his immediate wage he also earns a retirement wage is becoming more and more generally accepted. The OASDI legislation is based on this conception, though its application of it is less than complete.

Rigid enforcement of the original idea restricts pensions not only to workers of long service, but also to those who continue service for the employer up to the normal time of retirement. A man might serve faithfully and well during his working life but, because of working for several employers, receive nothing in the way of a pension even from an employer who granted pensions.

The vesting provisions of a pension plan determine the employee's right to the benefits provided by the employer's contributions. There may be full, partial, or no vesting; the vesting may be immediate or deferred. Full vesting would mean that, to the extent that a worker accumulated pension rights at the expense of the employer, he would retain them, so that, at 65 or other normal retirement age, he would receive total pension payments representing his accumulated rights. Partial vesting would entitle the worker to part of his accumulated benefit rights. Immediate vesting is seldom granted, but most plans provide for vesting after a specified period of service or of participation in the plan, attainment of a specified age, or some combination of the two. Sometimes the proportion of benefits that are vested increases with the number of years of service. Usually the vested benefit is available only as a pension at 65 (not immediate cash), and these pension benefits are forfeited if the employee withdraws any contributions he may have made himself under a contributory plan.

Vesting requirements have received increasing attention since the 1965 report of the President's Committee on Corporate Pension Funds and other Private Retirement and Welfare Programs, which recommended that pension plans receiving favorable federal-income-tax treatment be required to include some reasonable graded vesting provisions.[10]

Funding Methods

The simplest method of financing pensions is the pay-as-you-go plan. The employer using this plan, if it *is* a plan, pays the pension direct as current expense. Most formal plans, however, make provision in advance for payment of pensions by making funds available independent of the control of the employer. Because of interest earnings, this advance funding reduces the total dollar outlay of the employer. It also increases the likelihood that the employee will receive his promised benefit when he retires and allocates the cost of the pension plan more equitably over time. A possible disadvantage is that the employer might be able to earn a better return on these funds by keeping them invested in his own business.

Relatively few pension plans are fully funded; i.e., the plan is seldom suffi-

[10] "Public Policy and Private Pension Programs—A Report to the President on Private Employee Benefit Plans."

ciently funded to pay all active and retired employees the benefits they have earned up to the present time if the plan were to be terminated today. Most plans would be able to continue the benefits to retired persons and to pay some benefits to active workers. Often the absence of full funding is attributable to the failure to meet the cost of financing the pension rights accumulated through past service. The President's Committee on Corporate Pension Funds has urged a tightening of the funding requirements for favorable tax treatment.

Funding Agencies and Instruments

A pension plan may be self-insured or insured. Under a *self-insured trusteed* plan, the employer transfers funds periodically to a trustee, such as a bank, which invests the money and performs some other administrative functions. A consulting actuary advises the employer concerning his annual contributions and the adequacy of the pension fund. The plan is highly flexible with respect to the pension formula, the budgeting pattern, and the types of investment media. The opportunity to invest self-insured pension funds in common stock has in fact been one of the reasons why self-insured plans have become so popular since the Second World War. A possible disadvantage is that the mortality, investment, and expense risks are not transferred to a third party, as is true under an insured plan.

Under a group-deferred-annuity insured plan, the insurer contracts with the employer to pay pensions in accordance with a stated formula, the employer paying the necessary cost, which may or may not include employees' contributions deducted from earnings.

Considerations for group annuities are usually paid in single amounts for deferred annuities, i.e., as each employee is credited with a unit of retirement benefit, full payment is made to purchase that unit. For example, in the case presented on p. 358 the employer would, during the employee's first year of employment, purchase a deferred annuity that would pay $40 a month at age 65. In this way complete payment will have been made for all annuity rights accumulated at any time by each employee.[11] The responsibility for paying the pensions is transferred in this way to an insurer. This approach is less popular than it was formerly because it is less flexible than other plans with respect to benefit formulas, budgeting patterns, and investment media. For example, insurers can only invest a small portion of the premiums they receive under these plans in common stocks.

[11] Past-service benefits, however, may be only partially funded, particularly in the early years of the plan.

A more flexible insured plan involves a *deposit-administration* contract, under which the insurer receives agreed periodical payments estimated to be sufficient, holds the funds and guarantees their accumulation at a stated rate of interest,[12] and charges against the fund the purchase price of each employee's annuity as he retires. No guaranty is given that the fund will be adequate, though the insurer or an independent consultant advises the employer on the amounts that should be paid in. The payment of the annuity to the retired employee after its purchase is, however, a direct obligation of the insurer. This plan permits considerable flexibility with respect to benefit formulas and budgeting patterns. The deposits, however, can only be invested by the insurer in the same types of investments as group-deferred-annuity premiums.

A *separate-account* plan is the most recent and most flexible insured plan. A separate-account plan is basically a deposit-administration plan, but part or all of the employer's deposits are allocated to one or more accounts that are held separate from other assets of the insurer. These separate accounts can be invested in common stocks or some other investment. In many states, these separate accounts can be used to underwrite a variable annuity.

Not all insured pension plans involve group contracts. Small businesses usually transfer funds to a trustee who purchases individual retirement-annuity contracts for eligible employees.

In order to take advantage of both the trust-fund and insurance methods, provision for pensions may be made by combining them under *split-funding* plans. A part of the contributions is paid into the trust fund and part paid for insurance, individual contracts, group-permanent, or group annuities. The pension is paid from the combined sources.

Tax Considerations

A most important consideration in present-day pension planning is conformity of the plan to the requirements of the Internal Revenue Code and the applicable regulations of the Internal Revenue Service, in order that the employer's cost may be deductible from income for tax purposes and the employees' benefits be not subject to tax until received as pension payments. These requirements, in general, are that the plan shall not discriminate in favor of higher salaried employees as to eligibility, benefit formula, or retirement date.[13]

[12] Additional interest will be credited if earned and declared by the insurer.

[13] For more detailed consideration of pension plans see Dan M. McGill, "Fundamentals of Private Pensions," and J. M. Melone and E. T. Allen, Jr., "Pension Planning: Pensions, Profit-Sharing, and other Deferred Compensation Plans."

GROUP HEALTH INSURANCE

Group health insurance has had its principal development in recent years, though its origins antedate group life insurance. As in individual health insurance, there is much wider variety in contracts and methods than in life or pension plans. In addition, disability is complex, and moral hazard must be reckoned with. All of which is to be contrasted with the simplicity of life and pension insurance, where the facts of death or survival determine entitlement to benefits and where the insured has little direct influence on either one of them.

Temporary Disability Insurance

The ordinary fundamental disability cover is that providing cash payments for nonoccupational disability during a period of 13 or 26 weeks, and amounting to 50 or 66⅔ per cent of the worker's weekly earnings, subject to some maximum amount. The maximum weekly benefit seldom exceeds $60. Sickness benefits are not usually paid for the first 7 days of disability, although many plans pay from the first day if disability results from a nonoccupational accident.

Nonoccupational disability only is regularly covered, since occupational disability is generally covered under workmen's compensation laws. However, in some cases, group disability insurance is used to supplement compensation benefits, i.e., to pay the difference between the amount to which employees are entitled under the compensation law and that to which they are entitled under the group program, if the latter is larger.

In four states many employers are required to provide this type of protection for their employees.[14] In three of these states private insurers may provide the necessary protection.

Long-term Disability Insurance

Long-term disability insurance, which was practically nonexistent until the current decade, provides an income for totally disabled workers until some advanced age such as 65. No payments are made during a lengthy waiting period, such as 90 days or six months. This insurance is usually made available only to a business's higher-paid employees and supplements a paid-sick-leave plan or temporary disability insurance.

[14] See pp. 597–598.

Accidental Death and Dismemberment

Written only as a supplement to other group contracts, the accidental-death-and-dismemberment contract provides for payment of a stated amount for any one of the following losses: life, both hands, both feet, sight of both eyes, one hand and one foot, one hand and sight of one eye, or one foot and sight of one eye, as a result of accidental injury, and within 90 days of the occurrence of the injury. One-half the amount is payable for loss of one hand, one foot, or one eye. These contracts may cover only nonoccupational, or both occupational and nonoccupational, injuries.

Medical Expense Insurance

Group medical expense insurance, like individual medical expense insurance, includes protection underwritten by commercial insurers, Blue Cross and Blue Shield Associations, and independent plans. This insurance is particularly important because many more persons are protected under group medical expense insurance than under individual insurance.

Commercial Insurance

Group *hospital expense* insurance covers room and board and collateral hospital services. Benefits for the former may be paid as a specified amount per day of hospitalization, regardless of the accommodations used, but under most plans are limited to the actual cost of room and board up to a maximum. The employee is indemnified for the cost of incidental services, such as use of the operating room and laboratory facilities, up to a stated maximum. Contracts to cover hospital expense vary in unit amounts of benefits and periods of hospitalization covered. *Hospital-admissions plans* are operated by insurers and hospitals in a considerable number of areas. These plans provide for a form identifying the employee seeking admission to the hospital and indicating the extent of his coverage, together with a claim form on which the hospital may make claim and receive payment direct from the insurer.

Under *surgical-expense* contracts, benefits take the form of schedules of surgical procedures with the maximum amounts that will be paid as indemnity for expense incurred. They may be issued as riders to hospital-expense contracts or as separate policies.

Several degrees of reimbursement for physician's nonsurgical care may be provided under *in-hospital, total-disability,* and *comprehensive* plans. The first of these provides only for physician's care while hospitalized; the second, for care in case of serious disability; and the third, for care in all types of case.

Major medical expense insurance and comprehensive insurance, already explained on pp. 343–344, have proved particularly popular on a group basis. If a major-medical plan is superimposed on basic insurance, the deductible is usually either (1) the basic-plan benefits plus a specified amount or (2) the basic-plan benefits or a stated deductible amount, whichever is greater.

Medical expense insurance is usually written to cover dependents of the employee as well as the employee himself. Arrangements are frequently made for the employee to meet the entire cost of dependents' coverage.

In some health-insurance contracts (disability and medical-expense contracts) insured employees and their dependents covered under group-disability contracts are given the privilege of converting their group coverage to individual coverage. Most insurers will now include such provisions upon request, but this was not a common practice until recently. New York State requires that, at the option of the insured, group contracts of hospital or surgical expense insurance shall contain a provision giving a covered member the right so to convert.

Blue Cross and Blue Shield Plans

The benefits provided groups of employees under Blue Cross and Blue Shield plans are essentially those already described on pp. 344–345. Usually these associations provide more liberal benefits under their group contracts than under their individual contracts.

Independent Plans

For a description of the benefits provided groups and individuals by independent plans, see the earlier discussion of these plans on pp. 345–346.

GROUPS OTHER THAN EMPLOYEES

For the sake of simplicity group insurance has been explained in terms of the employees of a common employer. This insurance, while originally restricted to such groups, has now been extended to several other types of group.

Labor Unions

Labor unions may now singly, in association, or in association with one or more employers contract for group insurance covering their members (and dependents), the contract being issued to, and its administration being handled by, a trustee or the union. Jointly administered health and welfare plans and pension plans have become increasingly important in recent years.

Associations of Employers

Arrangements may be made for covering the employees of an association of employers or of affiliated employers.

Employees of Governmental Units

Government employees may also be covered under group contracts.

Debtors

Contracts of group life insurance (in all states) or of disability income insurance (in some states) may be written to cover the outstanding indebtedness of borrowers on personal notes, usually unsecured, or of persons buying merchandise or, in some cases, real estate on the installment plan, the insurance being payable on death or during disability, and the debt being correspondingly canceled.

Insurance covering these other groups is subject to various statutory restrictions and regulations. The purpose here is only to note its existence.

RELATED INSURANCE PLANS

Wholesale Insurance

Wholesale insurance is written to give certain of the advantages of group insurance to groups of persons not eligible for, or for other reasons not covered by, group insurance. Wholesale life insurance (now called *employee life insurance* by some) is written on the basis of a separate application from each member of the group. There is usually no medical examination, though the employee may be required to make a statement concerning his health. Bad risks may be declined. The amount of insurance is fixed by a formula, as in group insurance. The premium is paid by the employer but may be in part collected from the employees. Individual contracts may be issued, or a master policy may be issued to the employer with certificates to the employees. Wholesale disability insurance (usually called *franchise* insurance) is written on much the same basis, except that the group may also be a trade, labor, or professional association that makes arrangements for premiums to be paid through a central representative, and all insureds are covered by individual contracts. Here the insured usually pays the entire premium. All contracts are in the same *form*, but amounts and kinds of coverage may differ.

Blanket Disability Insurance

Blanket disability insurance covers an identifiable group of persons but no specific person except when he is a member of the group. It may be written to cover all passengers of a common carrier; employees of a common employer in connection with exceptional hazards incident to employment; students of an institution of learning; members of a volunteer fire, police, or first-aid department; members of an athletic team; campers at a camp; or any association of persons having a common interest. The contract is issued to the carrier, employer, association, or other similar interest, but the members of the group are insured and benefits are payable to them.

QUESTIONS

1 In what ways does group life insurance differ from ordinary individual life insurance?
2 How are employees under a group-life-insurance plan, who leave employment with an employer before retirement, protected against inability to secure individual insurance because of not being acceptable to an insurer?
3 As an employer, would you favor a contributory or a noncontributory group-life-insurance plan? Why?
4 An employer, operating a business with employees who have accumulated varying periods of service with him, and who has had no pension plan, desires to install such a plan. How should he deal with the problem of past-service benefits in setting up his benefit formula, and how can he finance these benefits?
5 What rights does a terminating employee possess under a pension plan?
6 For what reasons do employers adopt pension plans? How does each reason affect the terms of the plan?
7 As an employer, would you prefer an insured plan or a self-insured plan? Why?
8 Would you prefer to receive a pension as (*a*) a fixed annuity, (*b*) a variable annuity, or (c) a combination of the two?
9 How are group-disability-insurance plans coordinated with workmen's compensation laws?
10 Would you expect group life insurance or group medical expense insurance to have the greater effect on the sales of its individual insurance counterpart? Why?

3
INSURERS

The discussion thus far has dealt with the fundamentals of insurance and with the insurance contract, which defines the risk assumed by the insurer and the conditions under which it is assumed. One element of the contract has not been discussed, that which defines the relationship of the insurer as an organization to the insured.

It is the purpose of Part 3 to describe the various types of insurer, their origins and characteristics, and to explain their relationship to the insured. Insurers operated by governmental units will be discussed in Part 5, Chapters 36 to 38.

24
TYPES OF INSURERS

On first surveying the field and observing the keen competition between the several types of insurers, one is struck by their number and variety. However, all are variants of two fundamental types:

1 The cooperative, or membership, organization, operated solely, in theory at least, for the benefit of the members
2 The proprietary enterprise, serving as a risk carrier and as a means of profit to its proprietors

Both of these types are of ancient origin. The first is a natural product of the instinct of mankind that leads to association for common defense. Time out of mind, there have existed cooperative organizations that have paid some form of benefits to their members in event of various kinds of misfortune. In the beginning, they were not thought of as insurance organizations, for the theories of probability and of insurance based on the law of large numbers had not been heard of. But they were in fact insurance organizations.

The second type probably grew out of the credit requirements of enterprising traders. Bottomry and respondentia loans,[1] carrying a higher rate of interest than the market rate on good security but not repayable if the venture was lost, served when commerce was of small volume. But as volume increased, the more efficient system of insurance developed. The underwriter took the place of the moneylender as the risk bearer, and the interest rate and insurance premium were separated. At first the insurance was practically confined to marine risk, though the same underwriters sometimes wrote speculative life-insurance contracts on the lives of persons going on voyages. The London fire of 1666 suggested that the risk of fire might be cared for in the same way, and gradually the range of underwriting extended to the fields it now occupies.

[1] See p. 184.

ESSENTIAL MUTUALITY OF INSURANCE

There is a certain fundamental mutuality in the practice of insurance. This may be brought out by comparing the conditions underlying the conduct of that business with those underlying manufacturing or trading, in both of which large capital investment is required in the form of buildings and equipment before any product can be manufactured or any service rendered. Also, business may be suspended by either for an indefinite period and, if the physical property is protected against deterioration, may be resumed at will. True, the sales organizations would probably go to pieces, and a new clientele would have to be built up, so that it would be a serious disadvantage to suspend, but it can be done and is done, in manufacturing at least, for no inconsiderable periods.

No extensive physical capital is required to enable an insurance enterprise to serve the public. Legal restrictions aside, all that is required is an underwriting staff properly to rate and select the business, a clerical staff to record transactions, an adjusting staff to settle claims, and a competent set of directors to supervise the enterprise and conserve funds. This is a little more elaborate organization than is required by the other types of enterprise. But the most skilled organization in the world could not serve as an insurer unless there were a sufficient number of exposures insured to furnish a stable experience under the operation of the law of large numbers. Having acquired a volume of insured exposures, it could not suspend and revive its operations at will. For it could not do so and have at all times the volume of business necessary for successful operation under this law. In short, the insurance business can furnish insurance only by having a body of insureds. If the comparison may be continued in metaphor, the commodity that the insurer manufactures (certainty) is produced by natural laws from the raw material (risk) which it can acquire only by doing business. In essence, then, it is the group of insureds who insure each individual in the group by transferring their individual risks to a common risk bearer.

It follows from this that a properly organized and soundly managed membership insurance enterprise should be able to serve society well. But it does not follow that all such enterprises regardless of management must succeed, nor does it follow that it may not prove desirable to act through a professional risk bearer operated for profit.

PROPRIETARY ENTERPRISES

Three types of proprietary enterprises have served as insurers:

1 Private individuals or copartnerships operating alone
2 Private individuals, copartnerships, or syndicates of individuals operating as Lloyd's Associations

3 Groups of private individuals organized as insurance corporations

The earliest insurers were individuals who wrote insurance either as a side line or as their principal or exclusive business. The first offices for fire insurance were started after the London fire by private individuals. During the following century several such offices were established. Early records show the existence of private underwriters in colonial America, but they have now passed entirely from the stage.

Lloyd's Associations

Lloyd's, London. Lloyd's, London, is an incorporated body and is the leading factor in the marine-insurance field, as well as of outstanding importance in other insurance fields, with the exception of life, in which only a small amount of short-term business is done. *But the corporation as such does not conduct an insurance business.*

The membership of Lloyd's consists principally of *underwriters,* of whom there are over 5,000—individuals who carry on an insurance business in *The Room.* These underwriters, or "Names," as they are commonly called, who may or may not be men skilled in insurance, operate through *Syndicates,* which vary greatly in size. Some include only a few members; others have over 50 members. Each Syndicate is managed by an underwriting agent who has a seat in The Room and who carries on an insurance business for the members of the Syndicate. "He may be himself an underwriting member of Lloyd's and may be included as one of the Names [members] in his Syndicate, or he may be merely an agent for his Syndicate. . . ."[2] Whatever insurance he writes is divided among the members of his Syndicate in accordance with agreed shares, and each member is responsible only for his share. For example, if the underwriting agent insures a risk in the amount of £1,000, and the 10 members of his Syndicate have each agreed to take 10 per cent of its writings, each member would insure the risk of £100 and would have contracted in that amount with the insured, "each for himself and not one for another." In most Syndicates the proportions of the individual members vary considerably. The insurance afforded by a Lloyd's contract may be underwritten by one or more syndicates, frequently by a considerable number, each being responsible only for the amount accepted by its underwriting agent.[3]

Admission to membership in Lloyd's is subject to careful investigation and approval by the Committee of Lloyd's, and the member must make a substantial deposit, show that he is financially sound, agree to a limitation on his annual premium income, agree to pay his premiums into a trust fund from

[2] C. E. Golding and D. King-Page, "Lloyds," pp. 32–33.

[3] There are also underwriting syndicates in Glasgow which do an insurance business on the same principles.

which his underwriting liabilities must be satisfied before he may claim any remaining balance, and submit to *The Audit*, a searching annual examination into the affairs of each Syndicate. His liability is unlimited; his entire financial resources may be levied upon to meet his obligations.

The insurance written at Lloyd's is mostly of standard sorts such as are written by insurers throughout the world. But since each underwriting agent is in a position to consider and decide what risks his Syndicate will take and on what terms, Lloyd's furnishes a market for insurance that cannot be placed elsewhere, or that requires special, individual treatment. Many new forms of insurance have originated at Lloyd's, and spectacular (and perhaps speculative) proposals find their market there. The underwriters also offer facilities for increasing the capacity of other insurers through reinsurance.[4]

In addition to the members of Lloyd's the following are entitled to use The Room:[5]

> *Annual Subscribers*, who consist mostly of principals and the senior employees of brokerage firms.
>
> *Substitutes*, who are those employed in a clerical capacity, either by underwriters or by brokers.
>
> *Associates*, who are persons whose work brings them into touch with members or subscribers, for the purpose of carrying out certain professional services connected with insurance. They include average adjusters, claims assessors, accountants, solicitors, and other professional men.
>
> The British marine-insurance companies, almost without exception, also pay a subscription to Lloyd's in return for which their accredited representatives may enter the Underwriting Room for the purpose of obtaining information and discussing technical matters with Lloyd's underwriters, but they may not transact any insurance business within the Underwriting Room. For their subscription, the marine companies also obtain certain shipping intelligence from Lloyd's.

Insurance is placed at Lloyd's only by brokers (or their employees) who are Annual Subscribers and who are known as *Lloyd's brokers*.

The principal service of the Corporation of Lloyd's to the insuring public and to its members is its supervision of membership and of the operations of its members. But it also furnishes numerous other services. *Lloyd's Agents*, located throughout the maritime world, report shipping news to London and also serve shipowners, cargo owners, or underwriters in dealing with losses, including salvage operations. Through its *Intelligence Department* and numerous publications it furnishes extensive information on matters of particular concern to insurance and shipping interests. Salvage operations have been

[4] See pp. 470–472.

[5] Golding and King-Page, *op. cit.*, pp. 49–50.

made more effective and put on a sounder basis by the promotion and use of *Lloyd's Form of Salvage Agreement*. *Lloyd's Policy Signing Office* serves the members by handling the details of issuing and recording policy contracts. *The Claims Office* settles claims for the underwriters, both at home and abroad. *The Salvage Association (The Association for the Protection of Commercial Interests as Respects Wrecked and Damaged Property)* is operated by Lloyd's and other marine-insurance interests for the purpose indicated by its long title. It carries on no salvage work itself but makes arrangements for such work and supervises it.

Lloyd's Register of Shipping, while not published by Lloyd's (it is published by the Society of Lloyd's Register), is so closely identified with that organization as to be regarded as one of its services. The Register is a reference book, periodically revised, giving information on ships surveyed by the Society during or after construction. The information covers the points knowledge of which is essential to an underwriter insuring the vessel or to anyone interested in its quality.

Underwriters at Lloyd's are admitted to write insurance in the United States only in Illinois and Kentucky, but insurance may be placed at Lloyd's in London or through Canada. Reinsurance and excess lines[6] may be placed also through United States intermediaries. While Lloyd's underwriters may not write insurance in most states, their representatives settle losses throughout the country, and a special American Trust Fund is on deposit in New York as security for the payment of losses.[7]

Lloyds in the United States. Lloyds organizations in the United States have little in common with Lloyd's, London. They are unincorporated associations of individuals, each of whom has agreed to accept a definite share of each insurance written. As at Lloyd's, London, the liability is several and not joint. The liability of each individual varies. In some cases he has no liability beyond the amount of a deposit; in others he may assume limited or unlimited liability beyond the deposit. The management of these associations is entrusted to an attorney-in-fact who represents the individual underwriters.

Lloyds associations do not write life insurance and write a very small part of the total insurance other than life.[8] The bulk of their business is automobile physical damage insurance.

[6] See p. 555, footnote 21.

[7] For more extensive explanation of Lloyd's and of activities at Lloyd's, see Golding and King-Page, *op. cit.*; D. E. W. Gibbs, "Lloyd's of London"; and, for Illinois data, *Report of Examination . . . of the conditions and affairs of the Underwriters at Lloyd's, London.*

[8] For further information on Lloyds in the United States, see *Best's Insurance Reports, Fire and Casualty*, section headed "Lloyds" Organizations.

Stock Corporations

Stock corporations may be formed in all states to write insurance. The essential characteristic of a stock insurer is its issuance of capital stock as evidence of investment by the original stockholders and as evidence of ownership and control of the corporation. The stockholders elect directors who, in turn, elect executive officers and who in greater or lesser degree supervise the conduct of the business.[9] The original stockholders are usually required to pay in 150 per cent of the par value of the capital stock and often actually pay in a much larger percentage.

The stock insurer is normally formed for the purpose of making profits for the stockholders but not necessarily so. In some cases, where profit has not been the motive, stock insurers have been formed because of the greater difficulty of forming other types or to facilitate control.

It is a general, but not an essential, characteristic of the stock insurer that it charges a fixed premium for insurance, the insured not being subject to assessment or entitled to share in surplus earnings. However, some stock insurers write all or part of their insurance on a *participating* basis, charging a premium that will be the maximum cost of the insurance but returning a *dividend* to the insured. Participating stock insurers are found in greatest proportion in the life-insurance business, but they operate to some extent in other fields, particularly workmen's compensation insurance.[10]

Except in the life-insurance field the larger insurers, doing a multiple-line business over a wide territory, are generally, but not exclusively, of the stock type. They usually write insurance only through independent agents or brokers, but some large stock insurers employ exclusive agents or sales representatives.

COOPERATIVE ENTERPRISES

There are four types of cooperative, or membership, insurer:

1 Pure assessment mutual associations or corporations
2 Advance-premium mutual corporations
3 Reciprocal exchanges
4 Fraternal benefit societies

[9] Requirements for the formation and continuance in business of stock and other insurers are discussed in Chapter 35.

[10] In many states all workmen's compensation insurers must charge the same rates.

Pure Assessment Mutual Associations

The *pure assessment mutual* insurers are more numerous than any other, for a large share of the rural and "county mutual" fire-insurance companies are of this type. As the individual concerns are small, however, the total volume of insurance in force in this class is relatively small. There are also several health insurers operating on this plan that have attained considerable size.

The organization is based on the idea of mutual aid, every insured being a member of the association. Usually the policies are for equal, or nearly equal, amounts, and each member has an equal voice in its control. The affairs are nominally conducted by a board of directors, and there are the usual officers. Not infrequently the secretary is the only paid officer and gives only part time to the work. When a loss occurs the officers, or a committee, adjust the loss, and an assessment is levied on the members in proportion to the amounts of their policies to raise enough to pay the loss. This is the simplest form of such an organization.

The larger organizations of this type usually try to maintain a fund sufficient to pay the claims likely to arise within a certain period in the future and levy assessments as may be needed to keep the current funds at about the estimated figure. Sometimes (usually by accident or health insurers), annual dues are assessed to care for the office expense; sometimes this amount is raised as a part of the claim assessment. The guarantee of the insurance lies in the right to assess all members.

The policy form for such an insurer is materially different from those discussed in Part 2. Sometimes it consists of a simple certificate of membership in the organization, the details of benefits and obligations being left to the constitution and by-laws. In other cases, the policy is, in most respects, substantially the same as for a stock corporation. In all cases, however, it is necessary to prescribe the manner in which the insured may be called upon for assessments. Some states have standardized the policy forms of assessment fire-insurance associations.

Advance-premium Mutual Corporations

The *advance-premium mutual* charges premiums intended to be sufficient, or considerably more than sufficient, to enable it to meet all of its disbursements and to accumulate a surplus. Under its contracts it assumes the same obligations as do stock insurers, but by reason of making the contract the insured becomes a member of the mutual organization. The members own and (technically) control the mutual, are entitled to share in its surplus, and are responsible, within limits, for its obligations.

Insureds exercise control by electing the board of directors, which has the usual functions of such a board. In the case of mutuals insuring principally large risks or serving specialized groups, control by insureds is often effective, but control by insureds of mutuals insuring large numbers over a wide area is impractical.[11]

While mutuals distribute such surplus as it is not considered necessary to retain, there is considerable variation in their policy in determining premium-rate levels. In the nonlife fields, mutuals often charge the same premiums as do the nonparticipating stock companies, frequently being members of, or subscribing to, the same rate-making bureaus.[12] They ordinarily are enabled to pay dividends to insureds by lower losses, lower expenses, or both, but with principal emphasis on lower expenses. In some cases premium rates are calculated with a view to keeping surplus earnings at the minimum needed to accumulate surplus, any improvement in experience being reflected in lower rates rather than in dividends to insureds. In life insurance, where mutuals are typically the large insurers, some insurers charge a high premium in the expectation of paying large dividends; others, a low premium in the expectation of paying low dividends. The resulting net cost may be about the same in both cases.

Many mutuals (other than life) make a saving in expenses by dealing direct with insureds through exclusive agents or sales representatives and reflect this saving in dividends. Others, notably the New England general-writing (formerly thought of as dwelling-house) mutuals, operate through independent agents. Life-insurance mutuals operate almost always through exclusive agents.

Assessments. Life-insurance mutuals do not have the right to assess insureds; adverse experience causing costs to rise is met by reducing dividends if necessary. In other fields it is generally provided by state law that a mutual may write nonassessable contracts if it has a surplus over all liabilities equal to the capital required of stock insurers writing the same kind of insurance. Most mutuals that can qualify now issue nonassessable contracts. Formerly it was the usual practice to reserve the right to assess insureds if the mutual incurred a deficit, either as a going concern or in liquidation, in proportion to the amount of premium paid and usually limited to the amount of one additional premium.

The shift to nonassessable contracts is probably almost wholly due to the arguments of fixed-price competitors. At the same time that the change removes the risk of assessment it also removes an element of reserve strength.

[11] And perhaps fortunately.
[12] See pp. 502–505.

Contracts. The contract appropriate to a stock insurer requires little change for use by a mutual. Ordinarily but three additional clauses are required:

1 A brief clause providing for assessment liability, if any
2 A clause providing that the insured shall share in the surplus of the insurer
3 A clause notifying the insured that he is a member of the mutual and entitled to vote at annual meetings

Factory Mutuals. The factory-mutual insurance companies originated in the conviction of one Zachariah Allen, a New England textile manufacturer, that the frequent and disastrous fires common in textile plants in the early nineteenth century could be largely prevented and that the effects of such fires as continued to occur could be made much less serious. Unable to secure recognition in premium rates of the decreased probability of loss due to the application of his ideas of prevention in the construction of his own mill, he and other manufacturers promoted and established the first factory-mutual company to serve its members by studying methods of prevention of loss from fire and by insuring them against such loss.

From that beginning have developed the Factory Mutual Insurance Companies, an organization of five individual mutual insurers which cooperate for purposes of prevention, inspection, appraisals, and reinsurance. These companies maintain strict specifications for acceptance of risks which are, in general, high-grade factory and other properties, constructed and equipped with a view to preventing loss by fire or by allied hazards including accidents involving boilers and machinery. Their low level of losses is evidence of the success of their efforts.[13]

The Affiliated Factory Mutual Insurance Company, a stock insurer owned by the Factory Mutual Companies, insures properties that do not fully meet Factory Mutual standards. It is also licensed to write liability, marine, and multiple-line insurance.

A peculiarity of factory-mutual operations is the high deposit premium required from insureds and the high return of *unabsorbed* premium (i.e., the amount remaining after losses, expenses, and contribution to surplus have been met), which amounts to approximately 88 per cent of the premium on 1-year contracts and 64 per cent on 3-year contracts. Insureds meeting the Factory Mutual standards purchase their insurance from one of the five mutual insurers, which issues a policy for the full amount of protection. However, it reinsures most of the protection with the other four members of the

[13] The Factory Insurance Association is operated on similar principles by the stock companies, but the members of this association write most of their business directly with the public.

system, and a certificate attached to the policy shows the share covered by each insurer.

Savings-bank Life Insurance

In three states—Connecticut, Massachusetts, and New York—mutual savings banks may set up separate departments to conduct a life-insurance business. Other savings banks, and in Massachusetts certain other organizations, may act as agents of banks with life-insurance departments. Insurance is sold "over the counter," no sales commissions being paid. Agencies are paid a small fee for collecting premiums. The usual types of individual insurance contract are written, but annuity contracts are written only in Massachusetts. In Connecticut, each bank is limited by statute to a face amount of $5,000 on a single life; in Massachusetts, the limit is $5,000; and in New York, $10,000 (decreasing term insurance of $20,000 may be written in New York). The total amount of insurance that may be written by all banks on a single life is $5,000 in Connecticut, $10,000 in New York ($20,000 of decreasing term), and $38,000 in Massachusetts. The banks also write group insurance subject to a different set of limits.

Each insurance department is financially distinct from the banking department; neither participates in, nor incurs, any liability in connection with the operations of the other, except that in New York and Connecticut, the banking department advances the original surplus of the insurance department subject to repayment, with interest, as the financial condition of the insurance department warrants.

Certain actuarial and administrative functions are performed for the banks by a central office, and a fund guarantees the obligations of the banks' insurance departments. Provision is made for *unification of mortality*, those banks have a lower-than-average mortality contributing an actuarially determined amount to the central fund, which is then apportioned among the banks experiencing a higher-than-average mortality.

Reciprocal Exchanges

At a reciprocal (or interinsurance) exchange an unincorporated aggregation of individuals, firms, or corporations, called *subscribers*, exchange contracts of insurance through an *attorney-in-fact* who issues the contracts and manages the exchange. Each subscriber enters into a *subscribers' agreement*, under which the attorney-in-fact is given authority to represent the subscriber in insuring all other subscribers.

The attorney-in-fact may be an individual, a partnership, or a corporation.

His remuneration for services as manager of the reciprocal is usually a proportion of premiums. In general, the larger the percentage, the greater his responsibility for meeting expenses of operation. A few exchanges pay flat salaries to the attorney-in-fact. One group of exchanges owns the corporation which acts as their attorney-in-fact; these exchanges meet all their expenses and pay the attorney-in-fact only the amount necessary to meet its expenses as a corporation.

The subscribers choose a board of directors or an *advisory committee* from among their number, the powers of which are defined in the subscriber's agreement. These powers vary all the way from limited power over investments to power to remove the attorney-in-fact. Whatever their specified powers, they represent the interests of the subscribers.

Contracts. The insurance contracts of a reciprocal exchange are identical with, or similar to, those written by other types of insurer, with the addition of a *special-conditions* clause which usually provides that (1) the subscriber's agreement shall be a part of the contract, (2) the word "company" as used in the contract shall mean each subscriber, (3) the consideration is the agreement to exchange contracts with all other subscribers, and (4) the liability of each subscriber is several and not joint and is limited to the amount stipulated in the subscriber's agreement.

Assessments. Statutes regulating reciprocals usually provide for a minimum contingent liability for assessment of subscribers of one additional premium deposit and a maximum of a specified multiple of the deposit (never more than 10), the exact liability to be fixed by the subscriber's agreement. Nonassessable contracts may be written if the surplus of the exchange is maintained in an amount not less than the minimum capital and surplus required of stock companies doing the same kinds of business.

Subscribers' Accounts. Reciprocals in the purest form keep a separate account with each subscriber, crediting him with his premium deposits and his pro-rata (in accordance with the amount of his premium deposit or annual earned premium) share of earnings on investments, and debiting him with his pro-rata share of losses and expenses. The unused portion of his deposit is returned, less any surplus retained in the account in accordance with the subscriber's agreement. The accumulated surplus is usually equal to the subscriber's contingent liability, if any.

A subscriber may cancel his insurance contract and terminate his agreement

at any time, or both may expire without renewal. After making provision for fulfillment of his obligations under outstanding contracts, his account will be closed and any credit balance will be returned to him.

Many reciprocals, however, also maintain an undivided surplus account. In some instances there are no individual surplus accounts.

Reciprocal exchanges write no life insurance and less than 5 per cent of the property and liability insurance in force. They tend to specialize in automobile insurance, but some reciprocals are large insurers writing many kinds of insurance.

Fraternal Benefit Societies

The fraternal benefit society, a type of insurer combining social interest with risk bearing, is found in the United States as well as abroad in the field of life and disability insurance.[14]

The membership of the fraternal order is gathered in local organizations, such as lodges, chapters, or courts, for social, educational, and other purposes as well as insurance. The members share some common bond such as religion, ancestry, or occupation. To qualify as an insurer under the laws of most states, the order must operate on the lodge system and have a representative form of government and ritualistic work. It must be organized for the mutual benefit of the members and not for profit. Members are elected and admitted to the local bodies in accordance with the constitution, laws, and regulations of the supreme governing body, usually with secret initiation ceremonies.

The supreme governing body is a grand lodge or convention known by a name associated with the ritual of the order and usually meeting once in 2, 3, or 4 years. Representation in this body is usually by the officers or other elected representatives of the local lodges. The constitutions of the various orders differ in setting up the supreme body, but usually the vote of the several lodges is more or less in proportion to their membership. The supreme body lays down the general regulations for the order, including the terms of the contracts to be issued, the rates to be charged, and other like prescriptions, within the limits set by the laws of the states within which they operate.[15] It also elects the grand officers and grand trustees (known by various titles) who are responsible for carrying out its policies in conducting the affairs of the order during the interim between grand-lodge sessons. The head office is under their direction in much the same manner as that of a private corporation is managed by its officers and board of directors.

[14] In some states fraternal orders may be organized or operated to insure their members against fire. Their operations are usually limited to the insurance of small, isolated risks.

[15] State laws regarding fraternal insurance are to a great extent uniform.

The head office usually employs state and district managers and organizers who work with the officers and members of the local lodges in procuring new members and otherwise promoting the good of the order. Methods of selling fraternal insurance are increasingly like those of the life-insurance corporations, and many fraternals now make the sale of insurance their principal function.

The fraternal-life-insurance movement began in the United States with the founding of the Ancient Order of United Workmen (AOUW) by John Upchurch at Meadville, Pa., in 1868,[16] and has had a considerable growth. This particular order extended throughout the United States and had many imitators. By 1900 the fraternal movement was widely extended. It probably furnished life insurance to larger numbers than did the life-insurance companies. But the business was generally conducted on an unsound nonactuarial basis. The consequent increasing cost and disappointment of the older members, becoming apparent at about that time, tended to discredit the movement. The development of the automobile, good roads, the motion picture, and other modern forms of entertainment also tended to weaken the social attraction of the local lodges. The development of group insurance further provided for many of the class who were formerly largely attracted to fraternal insurance. Nevertheless many orders with large membership continue to exist.

The larger and more active orders now use contracts (called *certificates*) similar to those of the companies except that the fraternal contract is written, and is required by the laws of most states to be written, as an *open contract.*[17]

Until 1911 fraternal orders were subject to regulation in but few states, and in most of these the regulation was of little importance. As the result of legislation recommended by the National Convention (now Association) of Insurance Commissioners at its meeting in Mobile, Ala., in that year and modified by a conference held in New York the next year, fairly uniform statutes and regulations were adopted in most states. Further progress was made in the approval by the NAIC and the National Fraternal Congress of the *Uniform Fraternal Code*, which has been adopted in whole or in part by a considerable number of states. Under the spur of these laws and regulations the orders have generally readjusted their plan of operations so as to place them on a scientific actuarial basis and have since made solid progress.

Nonprofit Medical and Dental Service Prepayment

Nonprofit plans covering subscribers' costs of physicians' care, surgical procedures, and hospital services may be organized under special statutes designed to facilitate their formation and operation and to protect the rights of sub-

[16] Generally accepted, but not fully established.
[17] See p. 325.

scribers. These plans have been developed principally as Blue Cross (hospital service) and Blue Shield (medical and surgical-care) plans. While they are operated for the benefit of the subscribers and without pecuniary profit to anyone, they are not mutual insurers. Their operations were described in more detail in Chapter 22.

OTHER METHODS OF CLASSIFYING INSURERS

Insurers have been classified in this chapter according to their legal form of organization. In succeeding chapters it will become apparent that they can also be classified according to (1) their marketing system (independent-agency insurers, exclusive-agency insurers, and direct writers) and (2) their pricing mechanism (bureau insurers and independent insurers).[18]

QUESTIONS

1 In what sense is all insurance mutual insurance?
2 What are the *essential* differences between stock insurers and advance-premium mutual insurers? What are the customary but nonessential differences?
3 One frequently sees references to insurance being written "by Lloyd's" (London). What is the correct phrase?
4 Compare a reciprocal exchange with (a) a Lloyds association, (b) an advance-premium mutual.
5 What is the relationship between the insurance and the banking departments of a savings bank?
6 What are the essential characteristics of fraternal insurance?

[18] For other classifications of insurers, see C. A. Williams, Jr. and R. M. Heins, "Risk Management and Insurance," chap. 28.

25
SELECTING AN INSURER

Selecting an insurer is a difficult task because there are several criteria to be considered. This chapter describes the most important criteria, comments on the use of ratios as a method for comparing insurers, and lists the more important sources of information concerning an insurer's relative performance.

SELECTION CRITERIA

The same common sense should be applied to the choice of an insurer that one applies to the choice of a lawyer, plumber, physician, contractor, or other individual or organization with whom one contemplates making arrangements for goods or services. The qualities one looks for, the importance of the arrangement, and the significance of price will vary with the situation. So with insurance, the basic criteria are much the same as those applicable to other choices, but the emphasis and manner of application are different. The outstanding considerations are security, contract, service, attitude, and price.

Security

Security in insurance is ability to fulfill the express promises made by the insurer in the insurance contract, and to do those things that are impliedly promised by custom. It is largely a financial matter, though it is also a function of quality of management. To the extent that it is financial it means resources to pay losses and to render services, resources in the form of assets and prospective income. On management depend conservation of assets, maintenance of income holding disbursements to a proper level, and furnishing the type and quality of service promised. Of special interest are the management's pricing, reserve, underwriting (including reinsurance), and

investment policies. Background for understanding these policies will be provided in Chapters 27 through 30.

Security in different kinds of insurance has different implications. For example, consider the promise to pay a stated amount at death of a person now age 20, who agrees to pay a level premium throughout his lifetime; the promise to pay the amount of loss to an automobile caused by fire within 1 year; or the promise to pay damages for which the insured becomes liable and to represent the insured in settling or fighting claims for damages. The first requires almost entirely financial security over a long period; the second, prompt ascertainment of loss and negotiation of a settlement, and financial security for the period covered;[1] the third, resources for furnishing the promised services and paying damages whenever they may be awarded.

The prime purpose of insuring is to achieve security, and security is the first criterion by which to determine the relative desirability of an insurer. Perfect security does not exist; insurers can fail and many have done so. But careful investigation and judgment should enable a prospective insured to reduce the probability of failure almost to the vanishing point.

Contract

While insurance contracts are in large degree standardized, and while any one insurer offers a variety of contracts and endorsements, there are differences between insurers. Indeed, these differences have increased in number in recent years. Some offer broader contracts than others; some will go to greater lengths in amending contracts to suit individual cases; some specialize in particular types of contract or in contracts for particular types of situation.

The prospective insured may find that an insurer, otherwise acceptable, will not write the contract that he desires. He may find it necessary to select his insurer on the basis, in part, of its contract. On the other hand, he may desire a simple contract, of such a nature that it is offered by all or practically all insurers writing the insurance desired. In that case, his choice will rest on other considerations.

The more extensive the operations or the financial responsibilities of the insured and the more complicated this situation, the more important is careful adjustment of his insurance contract to his needs. He should not let himself be too easily persuaded that a possible loss is so remote that it need not be considered. The important point is what effect its occurrence would have on him if it did happen.

[1] Though insureds tend to renew contracts from year to year without repeated scrutiny of the security of insurers.

Service

In some kinds of insurance or situation, service may be as important or almost as important as security of payment of loss. Outstanding examples are boiler and machinery insurance and fire (and allied) insurance on high-grade factory risks. The insurer's purpose here should be to do everything practicable to forestall the losses for which indemnity is promised; by analysis of hazards, repeated inspection of property, laboratory work on prevention, and particularly in the case of boiler insurance by restoration of operations.

In life insurance, service takes the form of assistance in arranging programs of insurance and in adjusting the contract to the insured's needs, with less emphasis on service directly related to the carrying out of the contract. In liability and workmen's compensation insurance, prevention of loss and adjustment of claims are important considerations.

The insured should assess his needs for service and the ability of the particular insurer to meet his particular needs. The answer may be a matter of geography; two insurers might be well equipped with service facilities, but one might be better located to serve an insured. Or one might have engineers specially competent to deal with the problems of a particular industry.

Attitude

The attitude of an insurer is to be considered in connection with its other qualities. Its response to requests for service, its initiative in rendering service without specific request, its policy in making liberalized contract provisions available to insureds already on its books, its willingness to consider and meet special situations, its interpretation of contracts (whether liberal or technical) —all such characteristics are summed up in "attitude." The insured will do well to make this quality a consideration in selecting an insurer.

Price

Having determined that more than one insurer satisfies requirements under the heads that have been discussed, there is every reason to consider cost. *Cost* is defined as the initial premiums paid less any returns because of dividends or rate adjustments. In considering cost, the insured should not assume that a higher price buys a superior article, nor that a lower price is evidence of inferiority. But he should be sure that it is subordinated to getting what he needs and should remember that, while the amount of money that is expended in premiums may be small, the protection and service of insurance may be of tremendous importance. The amount of premiums paid is worthy

of thought in the interest of economy, but assurance that the assets of a business will not be seriously impaired in case of disaster should have precedence. And effort that would yield more if expended on the business or profession of the insured than would be saved by applying it to reducing premium costs is misdirected.

While remaining on guard against being seduced by mere cheapness, the careful buyer should take advantage of such lower prices as can be obtained without countervailing damage to his position.

Compromises

Compromises are often necessary, but they should be confined to considerations other than security. The considerations discussed in the preceding paragraphs are dealt with in the usual order of their importance. If one has a proper contract with a financially sound insurer, some concession can often be made in matters of service or attitude, and especially in price. It may be difficult to find an insurer that meets every requirement without qualifications.

RATIO ANALYSIS

Ratios of various kinds are a frequently used device for comparing insurers.

For example, the policyholders' surplus (capital + surplus) divided by the total liabilities is sometimes used to test relative solvency. Two other commonly used solvency measures are the ratios of the policyholders' surplus to the unearned premium reserve (a term described in Chapter 28) and the premiums written to the policyholders' surplus. Ratios of expenses incurred to premiums written are often used in cost comparisons. These ratios can be compared with certain rules of thumb, the experience of other insurers, and the same insurer's experience in earlier years. These ratios are valuable if properly used, but they lend themselves to fallacious argument. Ratios are generally useful only as starting points for determining the fact that produced them, and judgment is then properly applied to the facts. Over-all ratios often need to be interpreted in the light of ratios drawn from individual parts of the insurer's business.

For example, a high policyholders'-surplus ratio may indicate a strong security position. On the other hand, it may simply reflect an overstatement of the insurer's assets or an underestimation of its liabilities.

Suppose that one insurer operates on a ratio of expenses to premiums that is lower than the expense ratio of another and claims that it is, therefore, more efficient. The lower ratio may be due to efficiency, but it also may be

due to skimping on service to insureds or to unwise retrenchment that will show up in later difficulties. The higher ratio may be due to inefficiency, superior service to insureds, or careful provision for the future. These ratios in themselves mean nothing; the question is, what produced them? And was what produced them good or bad from the insured's point of view?

Another example: suppose that a manufacturer is considering the purchase of group disability insurance, where he will be the direct beneficiary of economical management of the insurer's group business. He is told that insurer A has an acquisition-cost ratio (ratio of cost of securing business to premiums) of 16.6 per cent, while insurer B has a ratio of 21.4 per cent. But further inquiry develops the following facts: each company writes $25 million of disability-insurance premiums; insurer A writes $20 million of group, and $5 million of individual-contract premiums; insurer B writes $5 million of group, and $20 million of individual-contract premiums; insurer A's acquisition-cost ratio is 12 per cent for group, and 35 per cent for individual, insurance; insurer B's is 7 per cent for group and 25 per cent for individual. Insurer B is acquiring each class of business at a lower rate but, because of the difference in distribution of its business, shows a higher over-all rate.[2]

Sources of Information

A large corporation can employ an insurance manager or a consultant who is well versed in the intricacies of insurance, but choosing an insurer may well be a puzzling problem to the person who is neither an expert in insurance nor in a position to employ one. He is in much the same position as the layman who chooses a doctor or a lawyer, or the nonmechanic who buys an automobile, and should apply much the same principles. The reputation of an insurer is not too difficult to learn; its approval to do business in states whose regulatory standards are high is in its favor; the insured may use the services of an agent or broker in whom he has confidence; his own continuing relationship with an insurer will give him an opportunity to form a judgment. While he is not in a position to make an expert judgment, he is by no means helpless.

For the insured who seeks more information than is to be secured by conversation and discussion, there are many sources. Reports of organizations that specialize in presenting current and historical data on insurers are available; there is considerable periodical literature; state insurance departments

[2] For further discussion of ratios and other statistical data that require careful interpretation, see G. F. Michelbacher, "Multiple-line Insurance," chap. 18, Ralph H. Blanchard, "Ratios," Chester M. Kellogg, "How Good Is Your Insurance Carrier?," and Chester M. Kellogg, "The Cost Factor."

issue annual reports; annual statements of insurers are public documents; and informing conferences are conducted by organizations.[3]

But the insured should be warned against fallacious and irrelevant arguments. The use of ratios has been discussed; there are many other pitfalls. Undue emphasis on the form of organization of an insurer is often heard, sometimes to the point of urging that one should "believe in" a particular form. There are great variations in quality among insurers of any one type, and the "best" insurer is the one that best meets the insured's needs. A high-grade insurer that is indicated in certain situations is not necessarily adapted to all situations. The insured would do well to be skeptical of general rules and to proceed from an analysis of his own special needs.

Lists of insurers that have ceased to do business are quite useless without inquiry whether the form of insurer was responsible for its failure, if failure there was. An insurer may cease doing business for many reasons other than failure, notably by merging with another that owns it and thereby losing its identity.

While an insured might be sufficiently convinced of the desirability of supporting private enterprise on the one hand, or a state enterprise on the other, to let his convictions influence the placing of insurance, he should realize that his decision is not purely the practical one of buying the best insurance. And here he should be especially on guard against fallacies and against reasoning that is based more on emotion than on practical fact.

QUESTIONS

1 What is the most important criterion to be used in selecting an insurer? How would you measure an insurer's performance according to this criterion?

2 Insurer A, a mutual, has had a lower loss ratio (ratio of losses to premiums) and a lower expense ratio (ratio of expenses to premiums) than insurer B, another mutual. If you were considering placing insurance with one of these insurers, what further facts would you seek?

3 Insurer C, a reciprocal writing direct, convinces you that it would carry your insurance at a lower net cost than insurer D, a stock company writing only through agents and brokers. What further facts would you seek?

4 What sources of information on insurer performance are available to the prospective insurer?

5 How important is the legal form of organization of the insurer in the selection process?

[3] See pp. 49–50. According to a recent study, the financial ratings of "Best's Insurance Reports" have been effective tools for avoiding delinquent insurers. See Herbert S. Denenberg, "Is 'A-Plus' Really a Passing Grade?"

4

THE INSURANCE MARKET AND THE PROBLEMS OF THE INSURER

One unfortunate effect of the statutory and practical separation of the insurance business into distinct fields is the lack of appreciation of those engaged in one field that the problems of that field have their correlatives in the others. Although there are encouraging developments in the direction of greater unity of understanding and practice, partly as a result of the multiple-line legislation described in Chapter 19 and the formation of more groups of insurers, including both life insurers and property and liability insurers, one still has the subconscious impression that the insurance business is not one but several. This attitude has tended to further the popular impression of extreme complexity of the business, generally to its detriment.

Independent adoption of insurance terms aggravates these difficulties. The same word may have quite different meanings in different lines of insurance.

Although there are vast differences in the details of the problems presented to the insurers in the different fields and although these problems take on different aspects according to the nature of the insurer's organization, they do relate to things of the same nature. Their correct solution is governed by the same general principles.

It is the purpose of Part 4 to describe the insurance market and to outline these essential problems and the general principles governing them, as well as the more usual practical solutions of general application. Special adaptations of general principles and modifications of corresponding practices are necessary to meet the variations in conditions between fields of insurance or variations in the nature of the insurer. Much of such detail must be left to writers devoting their attention to special fields.

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THE INSURANCE MARKET

Need of Volume and Spread

The insurance market includes agents and other insurer representatives as well as brokers who in their purest form are legal representatives of the insured. Most insurance is purchased from United States insurers, but the international market, which is becoming increasingly important, will also be discussed in this chapter. Some mention will also be made of the unique methods of merchandising group insurance.

INSURERS' SALES ORGANIZATIONS

Since the insurance business in all its branches rests upon the law of large numbers, the stability of the rate of loss increases with an increase in the number of separate individual risks insured. Therefore, the stability of the insurer's experience will increase with an increase in the volume of its transactions, and it is to the interest of all insurers to seek as large a volume of business as they can properly handle. There are other cogent reasons why the managers of insurers seek an increasing volume of business. In the case of a stock corporation every increase in profitable business means larger aggregate profits for stockholders. Further, whether justified or not when applied to business, there is a popular impression that there is a natural law of growth and decline under which, when growth ceases, decline inevitably sets in and ultimately brings decadence and death. Consequently, there is a popular mistrust of any business that is not showing "progress," and even managers of mutual enterprises feel that they must satisfy this popular test.

Not only is a reasonably large aggregate volume of business necessary for the adequate operation of an insurer; a reasonably wide spread is also essential. It is fundamental to the operation of the law of large numbers that the individual risks be independent, that is, that the occurrence of the event insured against in one case shall not change the probability of its occurrence

in another. In contiguous risks this is usually not true. A fire in one house endangers that next door. One person with tuberculosis endangers those with whom he comes in contact. Too great concentration of risk becomes dangerous. If, for example, a fire-insurance company confined its operations to a single city, it might find its liabilities so great in the event of a conflagration that it could not possibly meet them. In fact, the early underwriters underestimated this possibility, and many insurers were so destroyed. An insurer writing workmen's compensation insurance in a single industry or region might find that a change in economic conditions that increased the accident hazard produced a serious problem for it, or that a shutdown of the plants of most of its insured would so cut down its business as to make its expenses an excessive proportion of its income. Such adverse fluctuations are not so likely to occur if the business is more widely spread in area, or over a large number of industries. But the natural working of economic forces, Emerson's mousetrap assertion to the contrary notwithstanding, does not bring the desired volume and spread. It must be sought.

Sales Organizations Necessary

There are instances of mutual insurers that have grown to large size through the recommendations of satisfied policyholders to their friends. These policyholders constitute in such cases a selling force, and they are usually constantly urged to this activity by letters from the management, not infrequently accompanied by offers of prizes and other special inducements. But these cases are relatively rare. Most insurers find a well-organized sales staff essential. This is especially true where a stock corporation attempts to secure risks located at considerable distances from its head office.

Sales Organizations by Type of Insurer

Although nearly every insurer has some sort of sales organization, the extent and form of the organization differ notably from one type of insurer to another. In the county mutual fire-insurance company, for example, the policyholders themselves seek to interest their neighbors in the venture, and the officers give a part of their time to such work, depending on the size and nature of the territory in which the company operates, the amount of their remuneration, and their estimate of the probability of developing a satisfactory permanent business for themselves.

The Factory Mutual Insurance Companies pay close attention to the elimination of hazard and have traveling inspectors and engineers on the road

constantly for that work. Working with and through their insureds they serve to spread knowledge of their companies and bring in new risks.

In some mutual companies, other than those writing life insurance but including many of the leading mutual insurers, and in some stock insurers, there are more-or-less elaborate systems of salaried solicitors working out of the home office or from branch offices under supervision of branch-office managers, or of other officials of the company in charge of their territory. Insurers whose contracts are sold by these salaried employees, or by mail, are *direct writers.*

The most elaborate and characteristic organization, however, is that of the typical stock property and liability insurer and many mutual insurers. These organizations consist of salaried home-office officials and other employees, salaried traveling representatives, salaried local representatives (if the insurer operates branch offices), and more or less independent agents working on their own time, paid by commissions, and representing several insurers. In most cases, brokers may place insurance either with agents or at offices maintained by the insurer and staffed by its own employees. These insurers are called *independent-agency insurers.* The recognition of the status of their agents as independent businessmen goes to the point of recognizing the *expiration list* of the agency as the private property of the agent, to which, on cancellation of the agency, the agent and not the insurer is entitled. By "expiration list," sometimes called *expirations,* is meant the record of names and addresses of present policyholders and the dates of expiration of their policies. The possessor of this list knows when and from whom to solicit renewals. Although insurers have the same data in their home-office records, they cannot legally or ethically supply them to a new agent.

Between these two types of sales organizations, i.e., the direct writers and the independent-agency insurers, but more closely allied with the former, are the *exclusive-agency insurers,* whose contracts are sold on a commission basis by persons representing one insurer exclusively. Life insurers usually fall in this category, as do some property and liability insurers of both the proprietary and cooperative varieties. Some writers, however, prefer to classify life insurers as independent-agency insurers because of the lifetime term of most life-insurance contracts and the vested renewal rights, described later in this chapter.

Specializing and General Insurance Agents

The specializing agent is one who deals in a single line of insurance, or in two or more closely related lines. He may sell a general line of insurance on the side, taking orders where they naturally fall to him, but devoting his primary

interest to his special field. The general insurance agent (not to be confused with the general agent) ordinarily sells all sorts of insurance except life, but may include life insurance in his offerings.

With the current tendency to combine insurers writing all types of insurance in single management groups, life insurance is becoming increasingly an offering of the general insurance agent. The managements of insurers writing other lines are acquiring or organizing life insurers, and more lately the managements of life insurers are extending their interests into the property-insurance field. Indeed, many insurers are now being reorganized as holding companies owning one or more life insurers, one or more property and liability insurers, a mutual-fund management and distribution facility, and other related financial services. Many agents are likewise extending the scope of their operations.[1]

FUNCTIONS AND POWERS OF THE INSURANCE AGENT

Authority of the Agent

The authority of an agent is delegated to him, and is restricted, by the *agency contract* between him and the insurer and by the insurance contract. But under the common law he has whatever authority is "apparent," in other words, whatever authority the public may reasonably be led to believe he has.[2]

Life Insurance. In life insurance the agent is primarily a salesman equipped with a rate book showing the rates, surrender values, and other features of policies issued by his company, as well as sample policies and application blanks. These correspond, respectively, to the price lists, samples, and order blanks of a merchandise salesman. The agent is expected diligently to canvass his field for his insurer, usually devoting his entire time to it, and canvassing only the type of person covered by his instructions. He is paid by a commission on the premiums for policies issued upon applications secured by him. The policy is sent to him for delivery, and his powers are limited to securing the application, delivering the policy, and collecting the premium. He cannot bind the company on the acceptance of risks or the settlement of

[1] For a recent analysis of insurance marketing problems and practices, see John S. Bickley, "An Overview of Insurance Marketing," *Journal of Risk and Insurance*, vol. 34, no. 2 (June, 1967), pp. 175–183.

[2] See Edwin W. Patterson, "Essentials of Insurance Law," pp. 478–482.

losses. However, if the insured pays the premium at the time he submits his application, the agent can issue the binding receipt described on p. 312.

While his primary function is that of salesman, the life-insurance agent is becoming more and more an adviser to his clients.

Many life-insurance companies insist on full-time exclusive representation and will accept business only from agents who conform to this requirement. Others accept business freely from general insurance agents and brokers doing a general business (who for this purpose are generally licensed as agents).

Health Insurance. Health insurance is sold by specializing agents, by general insurance agents, by life-insurance agents, and, to a considerable extent, by mail. With life-insurance companies increasing their activities in this field, greater interest in it is being shown by their agents. Life insurance and health insurance are complementary, since both are primarily concerned with the problems of the individual and his family.

Property and Liability Insurance. Most types of property and liability insurance are regularly sold through general insurance agents. Marine-insurance contracts may be arranged through general insurance agents, but the bulk of the business is concentrated at the seaports where it is written by insurers or underwriting agents with broad powers and placed by brokers representing insureds.

A general insurance agent usually has authority, within specified limits, to make and modify contracts of insurance and to receive notices on behalf of his principal, and he may be given authority, formally or informally, to settle losses of small amounts.

Typically, the general insurance agent handles all financial transactions with the insured, billing and collecting premiums and extending credit. He reports monthly to his insurers, who have no direct contact with the insured except, but not always, in the adjustment of losses. Following the success of many direct writers and exclusive-agency insurers whose representatives serve mostly to make the original sale, an increasing number of independent-agency insurers have turned to policy writing by the insurer and to *direct billing* and *automatic renewal*, with the insurer taking over the financial relationship, crediting the agent with commission at a lower rate than formerly. Insurers are seeking economy and identification by these practices; agents have tended to oppose these changes because of the expected weakening, under these practices, of their personal relationship with the insured.

Commissions

Agents are almost always paid by commissions, usually a straight percentage of premiums on each line of insurance, but there are many arrangements. A life-insurance agent usually receives a large percentage of the first year's premium, a smaller but substantial percentage of the second year's, and a small renewal commission for, say, 8 years. On a showing of personal-service contacts, a small commission may continue to be paid as long as the insurance contract is in force. Further rewards in the form of pensions are now common. Persistency is emphasized rather than mere first-year sales. Even if the agent terminates his association with the insurer, he usually receives his renewal commissions if he has completed some minimum period of service.

Many contracts in other fields provide for a moderate commission on all premiums. Commissions on large commercial accounts are often negotiated in order to reduce the premium to the level necessary to obtain or retain the client. Sometimes the insurer pays an additional *contingent commission* related to the profitableness to the insurer of the business done by the agent. Certain insurers, generally direct writers or exclusive-agency insurers, compensate their agents for selling the insurance in the first instance, billing of premiums and renewals being handled direct with the insured and without payment of any further commission or a smaller renewal commission.

Agency Supervision

A widespread network of agents requires a separate division of the insurer for their supervision and control. There are three systems of agency supervision in the United States, and although one or another of these will be particularly characteristic as the dominant policy of any given insurer, each will be found in use to some extent by many insurers. These systems are the *general-agency, branch-office,* and *direct-reporting systems.* Although the last is the system best adapted to, and most used by, small organizations operating in limited territory and is, therefore, probably the oldest, the first named is most used by corporations doing business over a wide area because it is best adapted to pioneering extension. In well-organized, closely built-up territory, the branch-office system has recently come into greater vogue. This is particularly true of life insurers and insurers writing a considerable volume of liability insurance. In workmen's compensation insurance the insurer promises to serve the employer by safety inspections and by investigation of claims for compensation. It must also audit payrolls to determine premiums. Under liability policies it promises claim service which must be prompt to be effective. Sometimes payroll audits are necessary under these policies. Insurers

may arrange with independent firms to perform these services, but insureds are generally better satisfied if they know that the insurer has facilities close at hand. This has led many companies to establish "service" branch offices. It is an easy and natural transition to convert such service offices to branch offices for agency work as well. Only a few mutual insurers now use the direct-reporting system exclusively.

General-agency System. Under the general-agency system, as it usually exists in the United States, contracts are made with individuals to represent the insurer in certain territorial divisions of the country for a fixed term defined in the contract. It is the duty of the general agent to cultivate his territory diligently and to arrange with a corps of agents and subagents to represent the insurer in the smaller sections of his field. He may receive business from brokers. He may be a personal producer. His contract provides for remuneration in the form of commissions on the business he develops. Sometimes his contract limits the commissions he may pay to agents; in other cases he has a free hand. He may pay some solicitors on a salary basis. In life insurance he may be called upon only to produce the business, i.e., to secure applications for insurance, or he may also handle certain routine relations with insureds. In other lines, e.g., fire insurance, he may represent the company on rate-making bodies and have wide discretion in accepting or rejecting risks. He may also have charge of loss settlements in his territory. Where his powers are so broad, his remuneration sometimes includes a profit-sharing arrangement based on the results of the business in his territory. This system is more often used by the younger and smaller stock companies.

The services expected of a general agent and the degree of power to bind the insurer vary greatly according to the kind of insurance and the business policy of the insurer. In some cases, particularly in marine insurance, the delegation of power is so full that he reports to the head office only in summary, and it is necessary for state officials examining his insurer also to examine his records and accounts if they are to get a true and complete picture of the insurer's operations and condition. In some cases the general agency is practically the equivalent of a regional branch office, as in the case of a general agency of a fire-insurance company for the entire Pacific coast, or assignment to the agency of practically full powers of selection of risks, making of contracts, and settlement of losses, subject to basic restrictions in the agency contract and routine checks by the home office. In other cases the designation as *general agent* is merely a courtesy title to lend apparent dignity to his position, perhaps give closer contact with the senior officers of the insurer, or make possible payment of a higher scale of commissions. Large

regional general agencies frequently represent several insurers and have their own staffs of fieldmen, auditors, and adjusters.

The general-agency system has two principal advantages: (1) the general agent is usually a resident of, and familiar with, his territory and in a position to attract business, and (2) the general agent usually finances the establishment of his agency and represents expense to the insurer only in proportion to the business he does for it.

Branch-office System. Under the branch-office system the field is covered by branch offices, each in charge of an officer of the insurer or a salaried manager. It is an extension of the head office into the field. The powers and duties of branch-office managers differ with the size of their territory and the business policy of the insurer. In many instances they have charge of all business of the insurer, with authority to settle losses and do other work. Many mutual companies are represented in this way outside the territory adjacent to their home office. The territory of a branch office may be cultivated by salaried men working from the office. This is often the practice of mutual companies other than life-insurance companies. It is the usual practice of stock companies to have local agents in the smaller places paid by commission. The purpose of the branch office is control over the business and convenience in service to and supervision of agents.

The principal advantage of the branch office is control of its personnel, methods, and relationships with agents and insureds. A general agent may well carry his agents with him if he changes insurers, and insureds may consider their relationship with him as paramount to that with the insurer. But the establishment of a branch office is expensive, and it may lack the personal touch of the general agent.

Certain large life insurers have set up what are, in effect, regional home offices, subject only to central control of fundamental business policies.

Direct-reporting System. Under the direct-reporting system there is direct contact between the local representative and the head office, without intervention of any general agent or branch office.

In many cases the insurer will make use of all three systems, a part of its territory being on each basis. In any case the general supervision of the business-getting work is in the hands of one or more of the senior officers of the company, usually of vice-presidential rank, with a corps of junior officials

to assist him. In a large insurer, there will often be a vice president in charge of each of the major territorial departments. The junior officials are called *agency superintendents or agency supervisors.*

The Special Agent or Fieldman

It is almost, if not quite, impossible to secure and maintain, by means of correspondence alone, adequate control of, and continuous enthusiastic activity among, a widely scattered group. This is true even when the territory is not very wide, as within the territory of a state, district general agent, or manager.

In the life-insurance business the usual means of securing these desiderata are periodic conventions by districts, at which one or more of the officers of the insurer are present. There are also national conventions which those producing a given volume of business are privileged to attend. This is a satisfactory method in this field where the agent usually works exclusively or principally for one insurer. But in the case of the property and liability lines it is hardly practicable.

In these branches of the business, contact between local agents and head, branch, or general-agency offices is secured through *special agents*, also called *fieldmen.* The special agent is a traveling representative usually assigned to a particular territory. It is his duty to see that his insurer is adequately represented in the communities in his territory. If there is a vacancy, he must seek a suitable person or firm to fill it and give instruction in the insurer's plans and methods. He must periodically visit the agencies in his territory and keep the good will of his agents. In the fire-insurance business in particular, where several insurers are frequently represented by the same firm, often a real-estate office, he must see that his insurer gets a fair share of the business and is not regarded by the agent as a dumping ground for the risks that others do not want. He must instruct his agents in business-getting methods and cooperate in securing difficult lines. He often accompanies the local agent to help him in making a sale, particularly when the sale requires explanation of a complicated or unusual form of insurance. If the agency is not satisfactory and cannot be made so, he must close it up and procure a new representative. He must periodically inspect the records and accounts of the agency and see that proper records are kept and that business is correctly reported. If the agent is not prompt in his accounting, he must ascertain the reason and correct it. If he is slow in remitting balances, the special agent must arrange to correct this difficulty, if possible, or "lift" the agency. If an agent gets into financial difficulties, a committee of special agents may take over the administration of his agency in order to salvage whatever value it has.

The duties of the special agent require a broad understanding both of the business as a whole and of the insurer's plans and practices in particular. Naturally, therefore, this position leads toward general executive work in the producing and underwriting departments of the insurer.

Home-office Training

Some insurers maintain home-office schools which may be attended by agents for instruction in contracts, rating, agency administration, and salesmanship. Others that do not maintain specialized training schools bring special groups to the home office for similar instruction and discussion.

Dual Loyalty of the Agent

The agent is the representative of the insurer and is charged with responsibility for scrupulously conserving its interests. In that capacity he owes it the highest loyalty. Practically, however, in many cases his representation of the insurer is only incidental to many other interests, as a real-estate dealer, banker, merchant, or other type of businessman. And his remuneration by the insurer depends on the business he produces for it. He can produce such business only by satisfying the people of his community that their interests are ever present in his mind. To retain the good will of large customers who have been or may be solicited by brokers, alert agents often offer as full service as do the brokers described below. They cannot, as agents, offer as wide a choice of insurers as the broker, for they must confine themselves to the insurers they represent. They may, however, act as brokers in placing risks with other insurers. In the large centers, *broker-agents* are becoming increasingly common.

If the interests of insureds conflict with those of the insurer the agent must decide between them, with the realization that he expects to continue to live and do business in his community. Naturally, therefore, there is great incentive to place the insureds' interests above those of the insurer. But if the agent is grossly unfair to the insurer, and his agency is lifted, he may not again be able to get a satisfactory connection, for despite the keenness of competition, insurers will not, in general, employ an agent who is known to have wronged another insurer. The insurer that accepted him might be the next victim.

BROKERS AND CONSULTANTS

Brokers

Just as a person unfamiliar with the technique of a market, unable to give careful attention to the details of a particular market, or unable to gain direct access to others in a market, will often employ another party to act for him as a broker, so the early traders used brokers to procure their marine insurance. Gradually the broker extended his activities to cover all lines of insurance. In most metropolitan centers are now found large numbers of insurance brokers, and some brokerage firms are nationwide or even international in their scope. The function of the broker is to act for the insured in handling his insurance problems. Although not declining to serve those whose insurance needs are limited, the broker specializes in serving those whose insurance needs are large and many-sided, especially large corporations.

A competent broker studies the insurance needs of a business firm and makes up a complete schedule of the kinds and amounts of insurance to be carried, including in the schedule the fidelity and surety bonds required. He investigates the physical condition of the plants and properties (often maintaining an engineering department in his office for that purpose) and recommends changes to reduce the hazard and to secure the lowest rate. He keeps records of expiration dates and calls attention to the needs for renewing expiring policies. He endeavors to keep in touch with inventories and advises as to the amount of insurance to cover them. He prepares suitable forms to give the most complete coverage on the best terms, with due regard to coinsurance and like conditions, and endeavors to see that the insured keeps within the limits of restrictive clauses in the policy. He places the insurance with insurers he considers good and keeps in touch with the condition of the insurers so as to be in a position to suggest changes, if advisable. If his client has a loss, he keeps in touch with the adjustment and tries to arrange a fair settlement. In short, the broker acts as the expert adviser of his client in regard to his insurance problems.[3]

For this service the broker is customarily paid a commission on the premium by the insurer with which he places the business. His commission may not be so large as that of an agent who is under contract with an insurer. The broker, who is a free lance and not tied to any single insurer, must place his business through an agency or the office of an insurer. When the business is

[3] The above statement deals with *competent* brokers of the highest type. Not all conform to this description.

placed through an agency the agent retains an overriding commission, which is his compensation for handling the broker's business.

Despite the fact that he is paid by the insurer, the broker, since he is free to place his business with any insurer, is not the insurer's agent. He has no contract with any insurer.[4] For the purpose of placing the business he is the agent of the insured. Knowledge communicated to him by his client is not the knowledge of the insurer as it would be if communicated direct to the insurer's agent. Misrepresentation or errors on his part are those of his client. These points should be borne in mind in procuring insurance through brokers, and the general standing and integrity of the broker should be very carefully scrutinized.

The broker's liability to his principal has been well put in the following court pronouncement:

> If a broker neglects to procure insurance or does not follow instructions when obligated so to do or if the policy obtained is void or materially defective through the broker's fault or if the principal suffers damage by any mistake or omission or commission of the broker, the broker is liable to his principal for any loss he may have sustained thereby.[5]

Although the broker is the agent of the insured for procuring the insurance, it does not follow that the insurer can always safely deal with him as the agent of the insured in other respects. For example, if the insurer desires to cancel, a notice of cancellation sent to the broker may not satisfy the policy requirement of notice to the insured. The powers of the broker to represent his client are only such as his contract with his client gives, or as others are led with the consent of his client to believe that he has. This sometimes causes no little perplexity to an insurance-company representative who may be called upon to cancel a policy. He wishes to retain the broker's good will in the interest of future business. Consequently he will be ill-advised to serve notice on the client over the broker's head. On the other hand, if he does not procure a valid cancellation, he may be liable to his company for breach of duty as its agent. Usually such a matter is handled by requesting the broker to replace the insurance elsewhere and return the policy for cancellation, allowing a little time for this before sending notice to the insured.

The broker's relations with insurers are necessarily very close. With such close relations, the custom has grown up of issuing policies at the request of

[4] In some cases an insurer may agree to pay a broker specified commissions, or even contingent commissions, or may authorize the broker to perform certain minor ministerial functions.

[5] *Johnson v. Illini Mutual Insurance Company et al.*, 18 Ill. App. 2d, 211 (1958).

brokers for their clients without ascertaining whether the broker has an order for them. The premiums on policies issued to brokers are not required to be paid immediately, the companies' metropolitan offices usually carrying accounts with the leading brokers. The accounts are charged with policies so delivered, and monthly settlements are required, with payment or cancellation within 60 days. This privilege has sometimes been abused by obtaining free insurance, sometimes with the connivance of the broker, sometimes without. For example, if a policy has been issued and charged to a broker it is technically in force, and if a loss occurs, claims may be made, the client ratifying the broker's action and paying the premium. This naturally is always done where a loss has occurred. If no loss has occurred, the insured may decline to take the policy on the ground that he did not authorize the broker's act. The broker then returns the policy as "not wanted" or "not taken." Efforts have been made to obtain a record of brokers who are persistent offenders in this regard, and even to force payment of pro-rata premiums. Since the funds of the companies arise only from premiums and investment earnings, this abuse of free insurance is at the expense of higher rates to all.

The courts have in some cases held that, where credit has been extended and the broker is given the policies to deliver and collects the premiums, he thereby becomes the agent of the insurer for that purpose. In some states there is statutory provision to that effect. Several have gone so far as to provide that any person who solicits applications for insurance, other than his own insurance, shall be deemed an agent of the insurer.

Insurance Consultants

Insurance consultants resemble brokers in that they serve as advisers and legally as agents for the insured. They differ from brokers in that they receive a fee for their services from the insured that is independent of the amount of insurance purchased. They do not place insurance with an agent or an insurer and do not share an agent's commission.

THE INTERNATIONAL MARKET

The international nature of marine insurance, the large values with which it deals, and its flexibility result in an international market and extensive negotiations in seeking the best and most economical coverage.

As an illustration, the cost to a Liverpool cotton merchant of a large consignment of cotton purchased in the New Orleans market may be taken. He must resell the cotton at a price that will reimburse him for the cost, including what he paid for the cotton, for the freight, and for insurance during trans-

portation, as well as all other expenses involved in landing the cotton at Liverpool. To the extent that the Liverpool price exceeds the sum of these costs he will make a profit.

If there are reputable underwriters in New Orleans who are offering insurance of cargo at a rate as low as, or lower than, can be obtained elsewhere, he may well buy in New Orleans c.i.f. (cost, insurance, and freight); meaning that the price paid includes these charges. But if there are underwriters in Liverpool, London, or elsewhere, in whose financial standing he has full confidence and who quote a lower rate, or otherwise offer more favorable terms, he will buy f.o.b. New Orleans and negotiate his insurance in the most favorable market. In international trade, the buyer, who pays the bill, is not a resident or, usually, a citizen of the country in which the cargo originates and is therefore not amenable to its laws, except as it may be possible to reach him through his goods. Were Louisiana to impose restrictions on the shipmen of cotton overseas, except under certain prescribed conditions as to insurance, it could do so only at the jeopardy of its trade. The marine-insurance business is internationally competitive, and there is considerably less standardization of forms or practices by statute than in other lines.

There is also considerable international competition for large lines of insurance other than marine and particularly for the business of insureds having establishments in several countries.[6] Some sorts of insurance that are not available here can be placed abroad, and often amounts in excess of the capacity of the American market are so placed—such insurances are usually effected through excess- or surplus-line brokers, who are specially licensed for the purpose.

Because of the prominence of Lloyd's underwriters during the days of the growth of the British trade, the immense overseas trade of Great Britain, and the importance generally of London in international trade, London and Lloyd's are still the world center of marine-insurance activity.

There are two international underwriting organizations representing groups of American insurers which maintain underwriting offices in foreign countries and write property and liability insurance for both American and foreign interests. At least one American insurer maintains its own offices in foreign countries.

GROUP-INSURANCE MARKETING

Group life and health insurance underwritten by commercial insurers is sold by commissioned agents and brokers, with agents selling the most contracts and brokers accounting for the most premium dollars because they tend to

[6] In recent years, nationalistic ideas, particularly in Latin America, have led to requirements that property be insured, and often reinsured, with domestic insurance institutions.

specialize in large accounts. These agents and brokers, however, receive considerable technical assistance from salaried insurer group representatives and other specialists in selling, installing, and servicing the plan. Commission rates are usually graded downward as the size of the annual premium increases. They are usually payable for 10 years on either a level basis or at a higher rate the first year followed by lower renewal rates for 9 years.

Blue Cross plans, Blue Shield plans, and most independent plans are usually marketed by salaried employees.

Group property and liability insurance has not been mentioned thus far in this text because it currently accounts for considerably less than 10 per cent of the total property-and-liability-insurance premium volume and it has only recently become a topic of major concern. In a recent comprehensive study of group property and liability insurance, Dr. James Chastain cited several reasons why the group concept has developed much less rapidly in this field than in life and health insurance.[7] Because the employer is the source of income payments interrupted by poor health, death, or retirement, he feels obligated to provide some protection against these perils, but he feels no similar obligation with respect to potential property or liability losses. Pressures to compete with the expanding social-insurance system have likewise been limited to potential losses caused by poor health, death, or retirement. Until recently property-and-liability insurers have had much less need for alternative marketing channels, primarily because it is easier to sell the need for adequate property and liability insurance than for life and health insurance. Agents selling individual insurance are more prone to resist group property and liability insurance than group life and health insurance[8] because the market for property and liability insurance is more nearly saturated and because group coverages are more likely to eliminate the need for any individual coverages. Because of this near saturation, public pressures for a new marketing channel are also small. Post-sales servicing needs are greater under property and liability insurance because of more difficult loss adjustments and changing exposures. In addition to other effects, this post-sales servicing makes the choice of the insurer more important to the group member and may reduce his interest in a particular group. The tighter rate regulation applicable to property and liability insurance, which is described in Chapter 35, has also been a retarding factor. Most state insurance departments are opposed in principle to group property and liability insurance because, among other things, they believe that it discriminates unfairly against nongroup members and the

[7] James J. Chastain, "An Evaluation of Group Property Insurance." See also J. J. Chastain, "Group Property and Liability Insurance," chap. 39 in R. D. Eilers and R. M. Crowe (eds.), "Group Insurance Handbook."

[8] Group life and health insurance, however, was also violently opposed by several groups before it became commonplace. Its extension beyond certain limits is still opposed, particularly by agents selling individual insurance, but also by others who are concerned about possible unsound underwriting.

higher-quality members of the group, threatens the present marketing system—the destruction of which would be against the public interest—would create a chaotic rating system, and would lead to insolvencies.[9] Finally, the tax incentives that have made group life and health insurance an attractive fringe benefit are not applicable to group property and liability insurance.

Nevertheless, ways have been found to write group property and liability insurance or related plans, and the demand for this coverage has increased. Intense competition in recent years has increased insurer interest in alternative marketing channels.

Dr. Chastain has noted that professional associations (such as medical societies sponsoring professional liability plans) and franchise-dealer groups (such as a chain of independently owned department stores sponsoring a property-insurance program) have been the most common groups demanding this coverage, and their demands usually involve business insurance, not family coverages. However, the demand for group family coverages is growing. One national union has already served notice that it intends to demand that the employers of its members provide automobile insurance as an employee benefit.[10]

Group property and liability insurance is being provided in a variety of ways: through nonadmitted alien insurers, through captive insurers, through special groupings for dividend purposes, by developing specialized package policies for specific groups, and by soliciting only group members.[11] A more recent development is the "mass-merchandising" plan, developed by several independent-agency insurers, under which individual policies are sold to the employees of a business on a payroll-deduction basis. This plan, which involves individual solicitation, underwriting, and policy issuance, is sold only through licensed agents. The rates are attractive because of claimed expense savings and improved loss-prevention opportunities. State regulators as a group have been less opposed to this plan because it represents less of a departure from the traditional marketing system than the true group approach, but this development has been severely criticized by many agents.

QUESTIONS

1 Why are mutual insurers interested in developing a sales organization?
2 Compare an independent-agency insurer with a direct writer.

[9] The same arguments were raised in opposition to group life and health insurance, but it must be admitted that there are some institutional differences in property and liability insurance. The real question is whether these arguments should prevent any group property and liability insurance or suggest regulations for its orderly development.

[10] For a recent comprehensive study of group family coverages, see Irving M. Field, "Employee Group Property and Liability Insurance."

[11] Eilers and Crowe, *op. cit.*, pp. 744–747.

3 Compare commission arrangements in life insurance with those in property and liability insurance.

4 How is the development of holding companies by insurers likely to affect insurance agents?

5 An insurance agent represents the ABC Insurance Co. and has been given authority to write contracts of fire insurance on dwellings in the amount of $10,000 or less, the company requiring him to refer proposals for larger amounts to the home office. He writes a contract for $12,000 on the dwelling of John Loring without such reference. Loring's dwelling is destroyed, and he proves a value of $14,000. May he collect $12,000 from the insurer?

6 What advantages to the insurer are characteristic of the general-agency system? Of the branch-office system?

7 An agent is the representative of the insurer, but depends on the public for business and on premiums for commissions. What should his attitude be in the light of this apparent conflict of interest?

8 An insured has correctly given the address of his dwelling for the purpose of effecting insurance on it as 342 West 113th Street. His broker gives the address to the insurer as 342 West 13th Street, and the contract is written to insure at that location. A loss otherwise covered by the contract occurs. May the insured collect? Had the error been made by an agent, could he collect?

9 Why do insureds sometimes purchase insurance from British insurers?

10 Do you believe that group property and liability insurance will become more important in the future?

27
PREMIUM RATES

The problem of rates (or prices) is at once the most important, the most complex, and the most difficult of all that confront the insurer. It is important because, if rates are too low, income will be inadequate; if too high, competition may have an advantage. It is complex because of the variations in hazard between lines of insurance, between contracts, and between insureds. It is difficult because all the costs that premiums based on the rates are intended to cover are incurred after the rates are fixed, sometimes long after, and because it involves probability calculations, exercise of judgment of the future, and consideration of a multitude of public and private questions. This discussion of insurance pricing will be divided into two parts: (1) some fundamentals common to all lines of insurance and (2) rate making by principal lines of insurance.

SOME FUNDAMENTALS

Insurance Rate Defined

An insurance rate is the unit price of a particular contract of insurance, for a particular person and/or financial interest, against specified loss, during a specified period. And these particulars are subject to almost infinite variation, permutation, and combination. If accurately calculated the rate measures the expected loss and expense per unit of insurance and allows a small margin for surplus.

Not only is the rate itself a problem but also the unit to which it is to be applied, for the premium (or total price) paid by the insured is the product of the number of units and the rate. If one buys $10,000 of ordinary life insurance at a rate of $25.36, the premium is $253.60, the unit of insurance being $1,000; the premium for $100,000 of fire insurance, at a rate of $0.23 per $100, is $230; the premium for workmen's compensation insurance for a

business with $1,000,000 of annual payroll, at a rate of $0.32 per $100, is $3,200; the premium for bodily-injury liability insurance (basic limits) on one car, at a rate of $56.20, is $56.20.

The rate may be said to measure the *quality* of a risk, varying inversely with its grade—the greater the expected loss and/or expense, the higher the rate. Given the rate, the number of units measures the *extent* of the risk. The units chosen for the various lines of insurance are not ideal, for considerations other than accurate measurement have their influence, particularly ease of ascertaining the number of units in any given case. Man-hours worked might be a better measure of extent than is payroll in workmen's compensation insurance, but payroll is easily determined, while determination of man-hours would be very difficult if not entirely impracticable.

The Ideal Rate

Under state laws and in the opinion of most observers[1] the ideal rate is one that produces from each large group of insureds of the same quality exactly enough income to insurers to meet the insurance losses and expenses attributable to the group, and in addition whatever margin is "reasonable" for the insurers covering these risks. Another way of putting it is to say that rates should be *adequate* but not *excessive* and should *discriminate* fairly between insureds. They should be adequate in order to provide insurers with sufficient income. They should not be excessive, for excessive rates impose undue burden on insureds. And they should discriminate fairly so that each insured will pay in accordance with the quality of his risk.

Calculation of the Rate

For the purpose of calculating a rate it is necessary to analyze it in terms of the items that it is expected to cover: broadly, losses, expenses, and a margin for surplus. These items may be further broken down into subclasses to the extent desirable and practicable in a given case. The end then sought is to determine what amount per unit of insurance will probably be needed to meet each class or subclass of disbursement. In making this determination the rate maker uses various combinations of statistical data (called *experience* by insurance men), mathematical calculations, and judgment. The extent to

[1] Some observers believe that insurers, like other businesses, should be permitted to recognize demand considerations, as well as costs, in their pricing. For a strong statement advocating some "unfair" price discrimination by life insurers, see Richard N. Farmer, "The Long Term Crisis in Life Insurance," *Journal of Risk and Insurance*, vol. 33, no. 4 (December, 1966), pp. 626–627.

which the various components play a part varies greatly, but judgment is always a part of rate making.

Simplifying the process, assume that in a given rating territory where a sufficient number of private passenger cars were insured to produce credible experience (say, 100,000 or more, each for a full year), the losses incurred under automobile bodily-injury-liability contracts were, for basic limits, $32 per car during the latest year for which experience is available. In the judgment of the rate maker, aided by a study of data to determine trends, losses during the period for which a rate is to be calculated may be expected to increase by 10 per cent over the losses experienced. Other things being equal, the provision for losses in the rate will be $35.20 ($32 + $3.20).

A similar determination of probable expenses would call for ascertainment of the amounts expended for various purposes such as adjustment of losses, general administration, inspection, and an estimate of any trend in their amounts, but it is the general practice to treat expenses as a percentage of the rate charged the insured and to use the same percentage over widely varying losses for a given line of insurance. Since a large share of expenses is in the form of commissions and taxes and since commissions and taxes are generally a percentage of the rate, this practice is not so inequitable as it might appear. To some extent, provision for expenses is calculated more realistically, but much remains to be done in this field.

Assume that, for this branch of automobile insurance, the provision for expenses is 40 per cent of the final rate, and that 5 per cent of the rate is to be allowed as a margin from which to build up surplus or pay dividends and for contingencies. The rate would then be determined as follows:

$$\frac{\$35.20}{1 - 0.45} = \$64 \text{ (rate charged insured)}$$

This rate would be designed primarily for use by the type of insurer whose losses and expenses were used in calculating it. The figures used would be fairly illustrative of the operations of nonparticipating stock insurers doing business through general insurance agents and brokers. Specialty insurers, direct-writing mutuals, insurers dealing with nonaverage insureds, or insurers having unusual plans of insurance might be able to justify rates varying from the norm or might have a different distribution of components.

Components of the Rate

The conventional analysis of the rate into provision for losses, expenses, and margin, and their further breakdown into types of loss, types of expense, and various marginal purposes, is serviceable for the calculation of rates. Ex-

amples of breakdowns of the major components are found in workmen's compensation insurance where analysis has been carried further than in most lines of insurance. Provision for losses may be divided into payments for medical care, serious losses, and nonserious losses; for expenses, into acquisition (mostly commissions to middlemen), payroll audit, inspection, bureau[2] (for support of rate-making and other organizations), adjustment, taxes, licenses, and fees, and general administration; for margin, into provision for contingencies and for profit. Each of these subclasses may be separately studied and appropriately treated in the rate calculation.

But this analysis obscures the purposes of the premium rate as a measure of the benefits received by insureds in exchange for their premium payments. A more instructive analysis of insurers' disbursements from this point of view follows:[3]

I. Direct benefits to insureds
   A. Loss payments
   B. Adjustment expenses (to the extent that they represent service to insureds)
   C. Expenses for prevention of losses
   D. Expenses for other service to insureds
   E. Surplus returned to insureds
II. Administrative expenses
III. Selling expense as such
IV. Margin
   A. Retained as surplus
   B. Distributed to others than insureds

Payment of losses, either to the insured (as in the case of damage to his property) or on his behalf (as in liability insurance), is clearly of benefit to him. Adjustment expenses, to the extent that they represent determinations that the insured would otherwise need to make himself, are for his benefit; to the extent that they are incurred to protect the insurer against excessive losses, they are a part of the insurer's administrative expenses. Expenses for prevention of loss are, in the long run, almost exclusively for the benefit of insureds, though they may inure to the benefit of insurers to the extent that losses are prevented without a compensating reduction of rate. Expenses for other service to insureds comprehend a wide variety of costs; principally they are those incurred in advising the insured, in arranging his insurance, and in

[2] See pp. 502–505 for a discussion of the nature and purpose of rating bureaus.

[3] Adapted from Ralph H. Blanchard, "Risk and Insurance," pp. 291–292.

drawing up plans and contracts. These services are usually performed in large part by middlemen; the insurer as such may perform them in whole or in part. Surplus is returned to insureds by participating insurers as a share in the excess of income over related disbursements.

> While it is evident that society is content to bear the net cost of maintaining the insurance institution, it is not often realized that this net cost is not the difference between premiums and losses, but the sum of the general administrative expenses, pure selling expense, surplus earnings, and such investment earnings as accrue to the insurer from funds advanced by insureds; a considerably smaller amount. And it is in return for this net cost that the broader benefits of insurance are received: knowledge of the existence of hazards, measurement of hazards, elimination of risk; all of which do their part in making possible modern business organization and operation, and contribute to personal and family security.[4]

Insureds receive direct value in return for their premiums in terms of losses paid and services rendered. Even if the insurance institution did not exist, the cost of these losses and services would have to be met. The operation of that institution entails certain costs that are the costs of maintaining the institution and, that are classified under II, III, and IV of the analysis on page 413. A cost not enumerated as such in the analysis arises from the payment of premiums in advance of many of the corresponding disbursements, furnishing insurers with a part of these funds for investment.

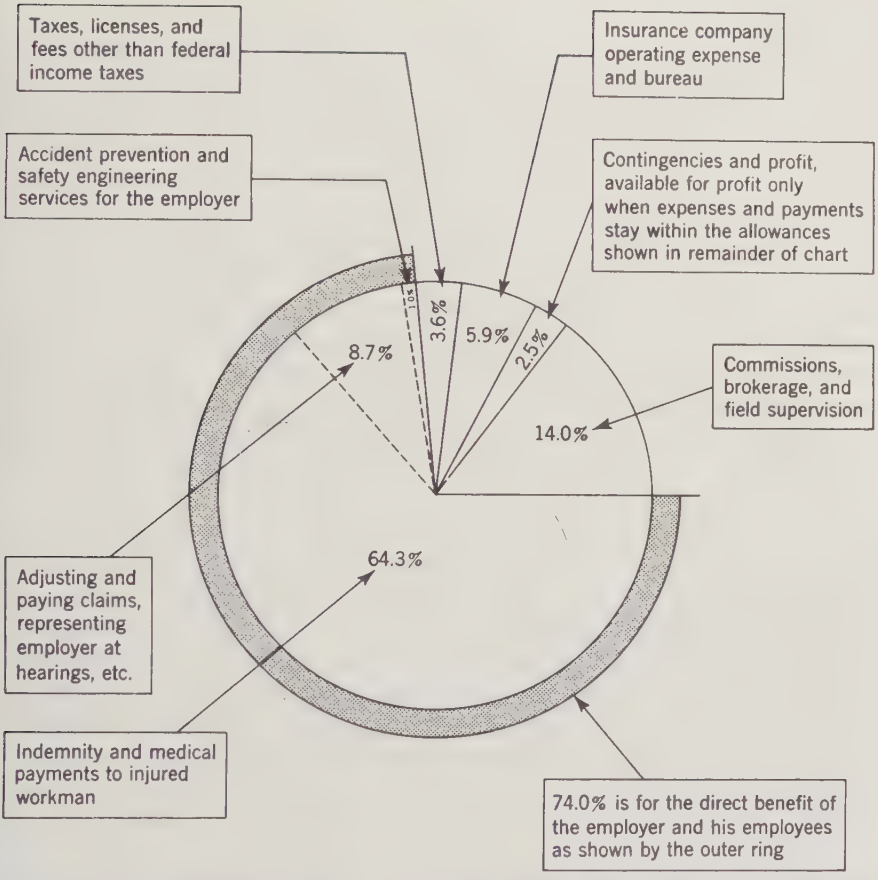
The chart on page 415 shows the components of that rate for workmen's compensation insurance based on the type of analysis presented above.

Accuracy of Rates

Something of a legend has grown up around the making of insurance rates. The impression has been created that insurance experts can make accurate prophecies of future losses and expenses by applying mathematical formulas to accumulated statistical data. While both statistical and actuarial procedures have been developed to a high point and have proved their usefulness, the fact remains that it is impossible to take into account all possible influences on insurance costs with sufficient accuracy to make rates that will exactly measure them.

The calculation of life-insurance rates is frequently cited as an example of scientific application of mathematics to the problem of accurate pricing.

[4] *Ibid.*, p. 292.


Taxes, licenses, and fees other than federal income taxes
Insurance company operating expense and bureau
Accident prevention and safety engineering services for the employer
Contingencies and profit, available for profit only when expenses and payments stay within the allowances shown in remainder of chart
1%
3.6%
5.9%
2.5%
8.7%
Commissions, brokerage, and field supervision
14.0%
64.3%
Adjusting and paying claims, representing employer at hearings, etc.
Indemnity and medical payments to injured workman
74.0% is for the direct benefit of the employer and his employees as shown by the outer ring

Workmen's compensation insurance, nonparticipating stock insurers. Expenses, by category, as a per cent of net premiums earned. (*Derived from* Insurance Expense Exhibit *compiled in 1967 by the National Council on Compensation Insurance and on an exhibit in the* Annual Report of the National Council on Compensation Insurance, 1965.)

Actually, the steady improvement in mortality over the years has resulted in life-insurance rates being adequate (or more than adequate). Even here, however, the decreasing rate of return on the investments of life insurers during the 1930's and 1940's made it necessary to return smaller dividends, or charge higher rates, to insureds. And the very fact of improving mortality that made life-insurance rates redundant involved insurers in losses on annuities. There is no intent here to question the security afforded to insureds by life insurance; the business has shown ability to adapt itself to changing circumstances and has operated in highly conservative fashion. The purpose is only

to indicate that, even in that branch of the insurance business where scientific methods have been most generally applied and with greatest success, it is impossible with any precision to know in advance what costs will be. Wars, economic conditions, medicine, politics, and other factors influence results, and what their influence is to be cannot be exactly known.

In other fields, data vary from nil to extensive accumulations, carefully analyzed. Method varies from pure judgment (informed guesswork) to the use of intricate mathematical processes. What is done in a particular line of insurance depends on the attitude of insurers, policies of state insurance departments, the competitive situation, available data, and the state of actuarial science in that line. The more nearly stable the situation from year to year, the more extensive the data, and the higher the degree of application of scientific procedures, the more accurate the rates may be expected to be. But judgment is always present, and conditions are always changing, so that precisely accurate rates are a chimera.

The Margin

Considerable controversy turns about the margin in the rate that is proper for nonparticipating insurers to allow for profit. Attempts are made to determine a "reasonable" percentage and to work out margins that are consistent as between different lines of insurance. In the past it has been customary to ignore investment income or profit in these determinations, but this position has been challenged more frequently in recent years as insurance rates have risen. These challenges will be discussed in more detail in Chapter 35. Agreements are frequently reached or decisions are made by regulatory authorities, and the allowable percentages are often bolstered by formula, analysis, or analogy. But still the only basis for determining any allowance for profit is the general concept that profit is justified to the extent that it induces insurers to furnish and to develop insurance in the public interest, to take the necessary trouble and risk. Agreements on what constitutes allowable underwriting profit have fixed on percentages varying from 0 to 5 per cent of premiums (not owners' equity), no one of which had any more than a consensus as its basis. Here, as in the case of losses and expenses, the results of writing insurance are often far different from those intended. It is not known whether greater profits would have been justified by a superior brand of insurance, or whether the world would have been as well off had insurers made less profit.

Much the same remarks apply to the margin for contingencies. By its very nature it represents preparation for the unexpected. To a great extent the margin is treated as provision "for profit and contingencies," without separation.

Margins in the rates of participating insurers are less a matter of controversy since they will presumably be readjusted by dividends to insureds. However, if they are large they may make competition more difficult, they tie up a certain amount of the insured's resources, and they hold a looser rein over the insurer than would more closely calculated margins.

Rates and Other Prices

Comparisons are frequently made between the level of insurance rates and that of the cost of living. Other comparisons are made between profits in insurance (as a percentage of premiums) and profits on dealing in various commodities or services—butter, furniture, clothing, electricity, telephones. In both cases, even though the figures may be accurate, the conclusions, express or implied, are usually fallacious.

Fire-insurance and similar rates are prices per money unit of insurance, e.g., $100, and are not comparable with prices of commodities. If the prices of insured property increase by 100 per cent, and full insurance to value is carried, it will require 100 per cent more insurance to cover the property, and the same increase in the premium paid, even though the premium *rate* does not change. Similarly with life insurance, if the cost of living doubles, the insured needs twice as much life insurance to make a given *real* provision for his family. Since the rate and the amount of insurance are both in terms of dollars, inflation influences the rate only to the extent that it increases the *expenses* of the insurer, and that influence is nullified to the extent that the amount of insurance purchased increases with the cost of living.

While the analysis presented in the preceding paragraph is correct for the examples cited, it is true that the rate of loss is in some cases increased as a result of inflation. Insureds may not increase insurance of property in the same proportion as increase in the cost of repairing or replacing it. In the absence of provision for coinsurance this situation will cause an increase in loss without equivalent increase in premiums. In liability insurance and in workmen's compensation insurance, increases in verdicts and in statutory benefits bring increases in losses in advance of any compensating increase in premium rates. Recent experience in automobile liability insurance has been strikingly illustrative of this fact, largely because the unit of insurance is the car, rather than an amount of money.

As to profits, each case must be judged by itself—one sort of commodity or service must be sold at a greater or lesser profit than another in accordance with the ratio of profit necessary to induce business to supply the public. Rate of turnover, risk involved, capital invested, and many other factors must be considered. Insurance profit, if it is to be judged, is justified only by its

relationship to the facts and concepts of the insurance business, not in comparison with the profit on other commodities or services.

Gross and Net Rates

The vagaries of insurance language and practice make difficult the choice of a heading for this section. The terms "gross" and "net" as applied to rates are used in life insurance. The gross rate is the rate charged to the insured, which includes provision for all needs of the insurer. The net rate is that part of the rate, calculated in accordance with a mortality table and an assumed rate of interest, that is intended to provide for the payment of losses. In liability insurance, the equivalent terms are *manual rate*[5] and *pure premium.*[6] In fire insurance no division is made in determining rates, but provision must be made in fire-insurance rates for losses, expenses, and margin as in rates for other lines of insurance, and the rates are revised on the basis of records of those factors.

Rating Methods

Insurance rating methods fall into three major categories: (1) individual rating, (2) class rating, and (3) modification or merit rating.

Individual Rating. Under individual rating, each insured pays a unique premium developed for him alone based upon everything that is known about his exposure, including the price quoted by a competitor. Although some statistical information may be available, and the characteristics of this prospective insured can be compared with those of present insureds, this method of pricing relies heavily upon the judgment of the person establishing the price. This method is limited for the most part to marine insurance, particularly ocean marine insurance, and to unusual exposures in other lines of insurance.

Class Rating. Class rating affects more insureds than any other rating method. Most life- and health-insurance rates are established in this way, as are most property- and liability-insurance rates for families and small businesses. Under this method, insureds are classified according to a (usually

[5] Or modification of the manual rate. See pp. 419–422.

[6] In some cases the pure premium may include certain loss-adjustment expenses allocable to the insurance for which the rate is calculated.

but not always) few important and easily identified characteristics, and the insureds in each class pay the same rate. Class rates are often called *manual* rates because they are printed in a rating manual that the producer or underwriter can consult to determine the appropriate rate for a particular insured. Class rating is relatively simple, objective, and speedy. Statistical data can be accumulated on the experience of each rating class. The attention paid to these statistical indications varies greatly among lines of insurance and among insurers, depending upon such factors as the credibility of the data available and prevailing pricing philosophies. Life-insurance, workmen's-compensation-insurance, and automobile-liability-insurance class rates have a strong experience base; in fire insurance and marine insurance, statistical data influence mostly changes in the general rate level for all classes combined.

Class rating, however, has its problems. The ideal class would be completely homogeneous as to hazard, i.e., the expected loss and expense would be the same for each unit of insurance. Actual classes only approach the ideal and often fall far short of attaining it. They are made up of insureds with certain, or even many, characteristics in common, but some insureds are better than the average, and some poorer. If a uniform rate for the group is charged, the better insureds will be paying more than their share; the poorer insureds, less. If allowance is to be made for these variations from the average, the problem is to measure the variation in the individual case. For most family and small-business situations, the variations are not important enough to justify the expense of a more refined pricing system. Large businesses, however, are more complex; a slight percentage variation in the rate can amount to a sizable dollar difference in premiums; and the percentage expense allowance in the premium need be increased only slightly to cover the costs of additional rating. This additional rating is called *modification* or *merit* rating and includes three major approaches: (1) schedule rating, (2) experience rating, and (3) retrospective rating.

Schedule Rating. Schedule rating is based on inspection of the insured's exposure to determine the extent to which conditions affecting the probability of loss depart from those of the average insured of the class. Credits (deductions from the manual rate) are allowed for better conditions, and charges (additions to the manual rate) are made for poorer conditions. The rater determines the proper charge or credit for a given condition by consulting a schedule of standards, with credits and charges for departures from the standard. The net result is the credit or charge to be applied to the rate. For example, if the manual rate is 0.68, the total credits 0.16, and the total charges, 0.11, the schedule rate is 0.63. A weak point in schedule rating is the preponderance of judgment in setting standards and in determining credits

and charges by physical inspections. Another difficulty is the changes constantly taking place in construction, equipment, and work methods.

Schedule rating has proved to be deficient when intangible factors such as workers' attitudes and morale are the most important factors. Schedule rating is most highly developed in the rating of business-fire-insurance exposures. Highly flexible schedules are also in frequent use in other lines to adjust the rates developed first by experience rating. The negotiated commissions described on p. 398 are a common feature of this combined experience and schedule rating.

Experience Rating. For insurance experience data to be useful, they must be drawn from a large enough number of cases to be *credible*, i.e., to be reliable as an indication of probable future experience. Other things being equal, the greater the number of cases the greater the *credibility*. But the search for homogeneity within a class for which data are to be compiled and rates made leads toward smaller groups and away from the required large numbers. The demand for recognition of the experience of individual insureds, even of single automobiles, is the ultimate expression of this tendency. *Experience rating*, as the term is used technically, means basing the rate in whole or in part on the experience of the individual insured. Just as there are insureds that are capable of sound self-insurance, so there are insureds that may properly be rated on their own experience. And there are many other insureds whose experience has some evidential value as a measure of their quality.

When experience rating was first proposed for use in workmen's compensation insurance, it was argued in opposition that it was contrary to sound insurance principles, since it reversed the idea of the many sharing the losses of the few. It was accepted only when the late Albert W. Whitney produced a mathematical formula that measured the relative credibility of the manual rate, based on the broad experience of a class of insureds, and that of the experience of the individual insured. Experience rating today, as used in workmen's compensation insurance and certain other lines, is essentially an application of that formula, though modifications for "practical" purposes have somewhat sullied the purity of the mathematics.

Under experience rating the manual rate is increased or decreased by the following modification:

$$\text{Experience modification} = \frac{\text{Actual losses during experience period} - \text{Expected losses during experience period}}{\text{Expected losses during experience period}} \times \text{Credibility factor}$$

The actual losses reflect the experience of the individual insured during the

experience period, which is usually a two- or three-year prior period. The expected losses are those that the insured would have experienced if he had been the average insured in his class. The credibility factor, which varies from 0 to 1, depends upon the relative credibility of the individual insured's experience compared with the class experience incorporated in the manual rate. The credibility factor is 0 for small insureds whose experience is considered to lack any relative credibility because of chance fluctuations; it increases as the size of the insured, as measured by its premium volume over the experience period, increases. To illustrate, assume that an insured would pay a class premium of $4,000 during the coming year and that he is eligible for experience rating. Further assume that his actual losses during the experience period were $3,000, his expected losses $6,000, and his credibility factor 50 per cent. His experience modification under these conditions would be:

$$\frac{\$3{,}000 - \$6{,}000}{\$6{,}000} \times 50\% = -25\%.$$

Consequently his experience premium would be $4,000 less 0.25($4,000) or $3,000. If his actual losses had been $12,000 instead of $3,000 but other conditions remained unchanged, his experience premium would become $4,000 plus 0.50($4,000) or $6,000.

Retrospective Rating. In still further search of a formula for relating the cost of insurance to the quality of the individual insured, and incidentally of persuading prospective insureds of the desirability of insurance as opposed to self-insurance, retrospective rating was devised. Experience rating is *prospective* rating; on the basis of past experience a definite rate for insurance during a future period is quoted. Retrospective rating adjusts the rate for a given period to reflect the experience of the insured during that period. Typically, the insurer charges a tentative premium that is subject to a refund or an additional payment as indicated by the experience of the insured. The experience is evaluated at intervals after the close of the insurance period, and final settlement is made in accordance with the indications. It is agreed that the final premium shall not be less than a stated percentage of the tentative premium, called the minimum premium, nor more than another stated percentage, called the maximum premium.[7]

What retrospective rating amounts to is self-insurance within limits, and an agreement that the insurer will give the usual service to the insured, par-

[7] There are variations of the plan, but all follow the same general principle.

ticularly in settlement of losses. It offers the insured an opportunity to benefit by a lower insurance cost if his experience is actually superior, but protects him against excessive loss if experience turns against him.

In addition to basing the premium on current loss experience, retrospective rating incorporates the wholesale principle described below with respect to the expense allowance in the premium.

Retrospective rating was primarily developed as a method of workmen's compensation insurance, but it is now largely used to rate combinations of lines and, under other names, is used in group insurance.

The Wholesale Principle

Until recently the wholesale principle of selling larger quantities at lower unit prices had not been formally applied in insurance. This was probably due partly to the fact that in many lines of insurance the expected loss per unit does not change with mere changes in *amount* of insurance. For example, the probability of death of each of three men who carry $5,000, $10,000 and $100,000 of life insurance respectively is, other things being *equal*, the same.[8] Furthermore, from the point of view of regulatory authorities, it has perhaps been felt that a uniform price for big business and small business, for the wealthy and for the less wealthy, is somehow "democratic."

But while losses per unit do not often decrease with amounts, many expenses do, and even percentage commissions may be arranged to decrease. Recognition of these facts is now accorded in many lines of insurance by the use of *graded expense loadings*, including *graded commissions*.

Based on a quite different principle are the differences in rate for successively larger amounts of insurance where the expectation of loss does vary with the increasing amounts, but increases less rapidly. In liability insurance, *contracts* for basic amounts cover most losses and expenses associated with losses. The expectation of loss under a contract for $5,000/$10,000 is not doubled by increasing the amount to $10,000/$20,000—it is increased by a matter of, say, 20 per cent. Further increases in like amount would increase the expectation of loss by *decreasing* percentages. These facts are recognized in rates that increase much less rapidly than the amounts of insurance.

Rates and Prevention

Recognition of reduction in losses, whether probable or actual, is a prime purpose of rate making. Broadly, such recognition appears in changes in the

[8] Insureds who carry very large amounts of insurance have experienced as a class higher mortality, but that has been so because other things were *not* equal.

rate level for a particular line of insurance but brings no very effective pressure to bear on individual insureds. Merit rating, of the kinds used in workmen's compensation insurance, and schedule rating, as used in fire insurance, are examples of systems of direct reward for prevention. In workmen's compensation insurance the reward is generally for demonstrated success in preventing losses; in fire insurance it is for adoption and application of methods and materials that, in the judgment of the rate makers based on long experience, will decrease the probability of losses. In the latter case, the insured can often be shown the results in rate savings that will be accomplished by a given expenditure for prevention.

A successful business is justified in expenditures for prevention that go beyond any prospective saving in insurance premiums. Losses that flow from casualties are often, perhaps usually, not fully insurable. Disruption of business and untoward effects on personnel should be considered. Business interruption insurance does not generally cover loss of customers, and workmen's compensation insurance does not cover loss due to interruption of manufacturing processes. It has been estimated that "compensation and medical payments constitute only one-fifth of the total employer accident cost."[9]

RATE MAKING BY PRINCIPAL LINES OF INSURANCE

The foregoing discussion has had to do with general principles of rate making. Individual lines of insurance have been dealt with only as illustrations have been drawn from them. While the underlying theory of rate making is universal, its application varies greatly from one line of insurance to another, both in the strictness and detail of its application and, seemingly, in the degree of consciousness of any such thing as principle.

Life Insurance

Life insurance has been the pioneer in evolving rate-making principles and applying them mathematically, but precision is hardly a characteristic of the results. This is not to say that greater precision should be sought, but only to state the fact.

The basis of life-insurance rates is the mortality table, a statement of expected deaths at each age of the range covered, in terms of an original *radix* or round number assumed to be living at the lowest age included in the table. There are different mortality tables for different groups, that in most general

[9] See H. W. Heinrich, "Industrial Accident Prevention," p. 50.

use being the Commissioners 1958 Standard Ordinary (CSO) Mortality Table (Table 27–1). This table was based on experience with *insured* lives from 1950 to 1954 and is conservative since the mortality rates in the table are somewhat higher than those actually experienced.

Each life insurer makes its own rates on the basis of this table or a table suited to a particular class of business or to the special characteristics of its own insureds.[10]

Life-insurance premium rates for individual insurance are class rates. Some illustrative rates were presented on p. 309. Calculating net-annual-level-premium rates is a two-step procedure. As an illustration assume that the task is to calculate the net level premium for a 20-year endowment contract. The first step is to calculate a *net single premium* for the unit of insurance, $1,000, i.e., a premium that, at a given age, if collected at the inception of the contract, would enable the insurer to pay $1,000 on the death, during the next 20 years, of each person insured and to pay the face amount to those who are expected to survive to the end of that period. It is assumed that deaths will occur as indicated by the mortality table and that a minimum rate of return will be earned on the funds collected in advance and invested between that time and the time of payment of the insurance.

While the result of this calculation, with an addition to cover expenses, would constitute a gross single premium, very few contracts call for such a premium. Premiums are usually paid in annual level amounts for the period of the contract or for some shorter period of time. The next step, therefore, is to calculate the level amounts to be paid annually for the premium-paying period, but not beyond the death of the insured, that would be equivalent to the net single premium. Allowance must be made for two effects of this arrangement: (1) the smaller investment return because smaller amounts will be invested, and (2) the varying numbers of annual premiums that will be paid by insureds who will die in different years.

When the *net annual level premium* has been determined, a sufficient loading is added to provide for expenses and whatever margin the insurer deems necessary. Since most life insurance is written under participating contracts, this loading may include a considerable margin for safety. Nonparticipating insurers take into account their own experience and work on a much closer margin.

Because of gradually improving (lessening) rates of mortality, life-insurance rates have been generally adequate or more than adequate. But rates of investment income that had been assumed as highly conservative (usually 3 per cent) were not being earned after the Second World War, which resulted in

[10] There are, for example, special tables for industrial insurance and for annuities. An instructive comparison of rates of mortality under various tables is presented in "Life Insurance Fact Book, 1968," pp. 108–109.

reductions in the assumptions to, generally, 2 to 2½ per cent. Commencing in 1955 income (before federal income taxes) has exceeded 3.5 per cent and in 1967 reached a comfortable 4.83 per cent.[11] The increased income serves to offset increased expenses and contributes to dividends. Many insurers have raised their investment income assumptions to 3 per cent.

The outstanding quality of life-insurance rates has been safety, tempered by the realization that there is no absolute safety. War, epidemics, and destruction of investment values are always a threat, even if remote.

The same tendency that has contributed to maintaining the adequacy of life-insurance rates has adversely affected the prices of annuities. Improving mortality experience means that people live longer and annuity rates must be increased. Decreasing investment returns during the thirties and forties further increased annuity prices. As a result, rates of return on life annuities are now very much lower than in the past—in a typical insurer, $1,000 would have bought a life income of almost $100 per year for a male at age 60 in 1918; it now buys about $75 which, however, because of increasing investment returns, is more than it would have bought a decade ago.

For ordinary life insurance, i.e., other than industrial or group, rates are quoted for *standard risks*—those applicants for life insurance who satisfy certain minimum requirements. Approximately 90 per cent of applicants are standard risks, and about 5 per cent are *substandard,* but acceptable on special terms; the remainder are unacceptable. Since applications for life insurance are usually not made by persons who are clearly unacceptable, the above percentages would be somewhat lower if all persons who would be willing to buy life insurance were considered.

Doubtless the standard risks might be classified by such factors as locality, occupation, grades of physical condition, and the rating system refined by charging appropriate rates for each class. However, it is the policy of life insurers to offer insurance at uniform rates for each age, sex, and contract type and amount to as wide a range of insurable persons as seems practicable.

Group life insurance and annuities involve experience rating in connection with dividends or retroactive rate adjustments.

Marine Insurance

At the opposite pole from life insurance, in the matter of rates, is ocean marine insurance, where rates are not published, and where there are no general tables or formulas for the calculation of rates. Each marine-insurance transaction of any moment is a matter of bargaining between the insured, usually represented by a broker, and the insurer. Marine-insurance rates, largely be-

[11] "Life Insurance Fact Book, 1968," p. 58.

Table 27–1 COMMISSIONERS 1958 STANDARD ORDINARY MORTALITY TABLE

Age	Number living	Number dying	Mortality rate per 1,000	Age	Number living	Number dying	Mortality rate per 1,000
0	10,000,000	70,800	7.08	32	9,439,447	21,239	2.25
1	9,929,200	17,475	1.76	33	9,418,208	21,850	2.32
2	9,911,725	15,066	1.52	34	9,396,358	22,551	2.40
3	9,896,659	14,449	1.46				
4	9,882,210	13,835	1.40	35	9,373,807	23,528	2.51
				36	9,350,279	24,685	2.64
5	9,868,375	13,322	1.35	37	9,325,594	26,112	2.80
6	9,855,053	12,812	1.30	38	9,299,482	27,991	3.01
7	9,842,241	12,401	1.26	39	9,271,491	30,132	3.25
8	9,829,840	12,091	1.23				
9	9,817,749	11,879	1.21	40	9,241,359	32,622	3.53
				41	9,208,737	35,362	3.84
10	9,805,870	11,865	1.21	42	9,173,375	38,253	4.17
11	9,794,005	12,047	1.23	43	9,135,122	41,382	4.53
12	9,781,958	12,325	1.26	44	9,093,740	44,741	4.92
13	9,769,633	12,896	1.32				
14	9,756,737	13,562	1.39	45	9,048,999	48,412	5.35
				46	9,000,587	52,473	5.83
15	9,743,175	14,225	1.46	47	8,948,114	56,910	6.36
16	9,728,950	14,983	1.54	48	8,891,204	61,794	6.95
17	9,713,967	15,737	1.62	49	8,829,410	67,104	7.60
18	9,698,230	16,390	1.69				
19	9,681,840	16,846	1.74	50	8,762,306	72,902	8.32
				51	8,689,404	79,160	9.11
20	9,664,994	17,300	1.79	52	8,610,244	85,758	9.96
21	9,647,694	17,655	1.83	53	8,524,486	92,832	10.89
22	9,630,039	17,912	1.86	54	8,431,654	100,337	11.90
23	9,612,127	18,167	1.89				
24	9,593,960	18,324	1.91	55	8,331,317	108,307	13.00
				56	8,223,010	116,849	14.21
25	9,575,636	18,481	1.93	57	8,106,161	125,970	15.54
26	9,557,155	18,732	1.96	58	7,980,191	135,663	17.00
27	9,538,423	18,981	1.99	59	7,844,528	145,830	18.59
28	9,519,442	19,324	2.03				
29	9,500,118	19,760	2.08	60	7,698,698	156,592	20.34
				61	7,542,106	167,736	22.24
30	9,480,358	20,193	2.13	62	7,374,370	179,271	24.31
31	9,460,165	20,718	2.19	63	7,195,099	191,174	26.57
				64	7,003,925	203,394	29.04

Table 27–1 COMMISSIONERS 1958 STANDARD ORDINARY MORTALITY (Continued)

Age	Number living	Number dying	Mortality rate per 1,000	Age	Number living	Number dying	Mortality rate per 1,000
65	6,800,531	215,917	31.75	83	1,792,639	249,858	139.38
66	6,584,614	228,749	34.74	84	1,542,781	231,433	150.01
67	6,355,865	241,777	38.04				
68	6,114,088	254,835	41.68	85	1,311,348	211,311	161.14
69	5,859,253	267,241	45.61	86	1,100,037	190,108	172.82
				87	909,929	168,455	185.13
70	5,592,012	278,426	49.79	88	741,474	146,997	198.25
71	5,313,586	287,731	54.15	89	594,477	126,303	212.46
72	5,025,855	294,766	58.65				
73	4,731,089	299,289	63.26	90	468,174	106,809	228.14
74	4,431,800	301,894	68.12	91	361,365	88,813	245.77
				92	272,552	72,480	265.93
75	4,129,906	303,011	73.37	93	200,072	57,881	289.30
76	3,826,895	303,014	79.18	94	142,191	45,026	316.66
77	3,523,881	301,997	85.70				
78	3,221,884	299,829	93.06	95	97,165	34,128	351.24
79	2,922,055	295,683	101.19	96	63,037	25,250	400.56
				97	37,787	18,456	488.42
80	2,626,372	288,848	109.98	98	19,331	12,916	668.15
81	2,337,524	278,983	119.35	99	6,415	6,415	1,000.00
82	2,058,541	265,902	129.17				

cause of the international nature of the business and the ability of insureds to protect their own interests, are exempt from governmental regulation.

In ocean marine insurance, as elsewhere, past experience is the guide to future rates, but there is much more latitude for the use of the personal knowledge and judgment of the underwriter, and for giving weight to general business policy.

Of particular importance to the marine underwriter in naming rates are the special hazards of geographical areas and seasons of the year, the record of the prospective insured and of the trade in which he is engaged, and the vessels which are to be operated or in which cargo is to be carried.

Inland Marine Insurance

The making of rates for inland marine insurance is peculiarly difficult because of the wide variety of covers, the small volume of business in many classes, and frequent marked differences between individual risks. Even where volume is

considerable there are so many factors affecting losses under an all-risks or multiple-peril cover that developing statistical evidence of the effect of each factor may be impracticable. The rates quoted for this branch of insurance are largely based on judgment, both individual and collective, corrected by such broad experience as is available and applicable.

These rates may be classified as class rates, schedule rates, or individual rates. The first of these classes of rates is for insured exposures that are reasonably uniform over considerable areas and are susceptible to a fair degree of statistical treatment. The second class is based on collective judgments of the weight to be given to the various factors affecting the rate as revealed in the proposals for insurance from prospective insureds. Sometimes experience rating is made a part of the schedule-rating process. For most insurers these first two classes of rates are promulgated by rating bureaus. The rates of the third class are almost purely judgment rates, though they reflect the personal experience of the insurer's underwriters.

Fire Insurance

Fire-insurance rates are of two general sorts: (1) *class, minimum,* or *tariff* rates and (2) *schedule* rates. The former are quoted for classes of risks in a given locality, modified to reflect differences in construction or fire protection. Schedule rates are made by the application of a schedule to the facts of a particular insured. The schedule starts with an assumed basis rate to which charges are added to reflect the features of the risk that increase the probability or the severity of loss and from which credits are deducted to reflect features decreasing that probability. The charges and credits, as well as the basis rate, are determined by judgment guided by statistical data. Rating bureaus play a prominent role in fire-insurance pricing, particularly with respect to schedule rating.

Except in a very broad way, fire-insurance rates are not based on statistical data. The general rate level and the rates for broad classes respond to experience, but, and this is particularly true of schedule rates, the rate charged for insurance on a particular risk is not arrived at by statistical processes.

Automobile Insurance

Rates for automobile insurance, both liability and physical damage, are based directly on recorded experience, with separate consideration of losses, expenses, and margin. In certain recent years rapidly increasing losses have necessitated increases based on observed trends to take effect in advance of availability of complete loss statistics. Competition between types of insurer

and competition based on special plans of insurance or rating have resulted in considerable variation in rates in this field. Insurers using rating-bureau rates account for less than half of the total premium volume.

Automobile-insurance rates are of particular interest to the public because of the widespread ownership of automobiles and the requirement, in some cases, of liability insurance as a condition of registration.[12] In congested areas the insurance premium may be a rather high percentage of the value of the car; in the case of used cars, sometimes over 100 per cent.

Most insureds pay class rates based upon such factors as the use of the automobile, the territory where the automobile will be principally garaged, the presence of young male (and sometimes female) drivers in the household, and the driving record of the insured household as measured by traffic violations and accidents. Two novel approaches consider grades in college courses and scores on psychological tests designed to test driver attitudes. Some observers object to the consideration of driving records on the ground that the accident experience of a single automobile is not credible enough to justify experience rating. The advocates of "merit-rating," as it is called, argue that merit rating is not technically experience rating on the basis of accident experience but is instead a more refined class rating system. Traffic violations are considered as well as accident experience, and insureds classified according to this additional criterion do develop different experience.

Experience rating, often followed by flexible schedule rating, and retrospective rating are important in establishing automobile-insurance prices for larger businesses.

Workmen's Compensation Insurance

In the making of rates for workmen's compensation insurance statistical and actuarial techniques have reached a high level of development. Rate makers in this branch of insurance are faced with a highly complicated problem and are subject to a wide variety of requirements and pressures.

Since workmen's compensation laws provide for benefits for injured workmen and since the insurance written under those laws is security for payment of the benefits, it is of particular concern to the government that the rates be adequate. And since employers are required to buy such insurance, the cost of which will presumably be passed along to consumers in prices, it is important that rates be not excessive and discriminate fairly between risks. Hence the strictly enforced requirements of insurance departments in charge of regulation of rates. And there is constant pressure from groups of em-

[12] See pp. 621–625.

ployers and individual employers on insurance departments, and on rate-making organizations—often exercised through insurers, agents, or brokers—to secure rates that will be "fair" and reflect the presumably superior qualities of their industries or establishments. Not least of the influences has been that of competition between types of insurer.

Rates are made for classes of business or classes of occupation by states and are, with some exceptions, subject to change even during the currency of a contract. These rates are modified, where practicable, to reflect conditions in the individual insured, and also to take account of the relative costs of insuring large and small insureds. The rate-making system is operated in some states by bureaus, each making rates for its own state; a national organization[13] makes rates for other states (except those with exclusive state funds). While the results of rate making for workmen's compensation insurance have not been ideal, it has been remarkably successful, largely because there has been a determined effort to take account of all factors influencing losses and expenses, and because, in spite of pressures, rates have been made with a reasonable degree of scientific detachment.

Health Insurance

Rates for health insurance have not been subjected to the same efforts to attain exactness or to so much governmental scrutiny as have rates in other fields. The result is that, while rates over-all are probably adequate and reasonable, they vary greatly in those qualities as between types of contract and branches of the business. As health insurance has grown and matured, however, the pricing of these contracts has acquired a more accurate base. Most individual health-insurance rates are class rates, but experience rating is a feature of group insurance.

A CLOSING COMMENT

There is probably no other business in which so great an endeavor is made to achieve fair prices as in insurance. And none in which prices are so subject to criticism, informed and capricious. The direct connection of insurance with many movements and enterprises of social import and its wide use in personal and business life are reasons for the interest in its premium rates, not only of insureds, but of politicians, journalists, and other public figures as well.

The departments of insurers, the organizations of insurers, and the rating officials of state insurance departments concerned with rating and enforcement

[13] See p. 505.

of rates add up to a considerable army. The results of their activities have been good, but one sometimes wonders whether there is not room for simplification and economy without damage to the public interest.

QUESTIONS

1 One frequently sees in newspapers comparisons of losses and premiums for a particular kind of insurance during a given year. Of what value is such a comparison?

2 Insurers writing a given line of insurance, say, workmen's compensation, experience during one period a large percentage of profit (considerably higher than had been contemplated by the rates charged) and during another period a large deficit. Are these facts evidence of improper rate making?

3 Insurers advertise a 5 per cent decrease in fire-insurance rates while the cost of living increases by 80 per cent. Is the comparison valid?

4 Assume that the net profit margin to the insurer on insurance is 5 per cent and on furniture to the manufacturer 10 per cent. What conclusion may properly be drawn from comparing these percentages?

5 An individual owner and operator of an automobile argues that his accident-free record of 10 years entitles him to a lower-than-average premium rate. Is his argument sound?

6 Is it proper to charge the same rate per unit of insurance, regardless of the total number of units involved in a given transaction?

7 On what basis would you determine the wisdom of expense for prevention of loss?

8 Compare retrospective rating with experience rating with respect to
   - **a** the use of credibility factors,
   - **b** the experience considered,
   - **c** the possible range in premiums.

9 What expenses incurred by an insurer directly benefit the insured?

10 Compare and contrast the pricing methods used in
   - **a** life insurance,
   - **b** fire insurance,
   - **c** automobile insurance,
   - **d** workmen's compensation insurance,

   with respect to the relative importance of
   - (1) rating bureaus,
   - (2) loss-experience data, and
   - (3) class rating.

28
RESERVES

The insurer's obligations under its contracts are, at the time of issuing the policy, all in the future, though the premiums are generally payable in advance. If an insurer were permitted to continue operations as long as it had no *matured* obligations that it could not meet (the ordinary commercial standard of solvency), it would in many, if not most, cases be perpetrating a fraud upon its patrons by using funds, paid to secure future protection and service, to meet already incurred obligations to others. The only way in which the business can be fairly conducted on an advance-premium basis is by making suitable provision in advance for obligations contracted to be met in the future, i.e., by setting up their present values as liabilities.

RESERVES AS LIABILITIES

The use of the term *reserve* to designate such present values creates a certain difficulty at the outset because the popularly accepted concept of a reserve is a fund or stock of resources, not otherwise required, voluntarily set aside for a particular purpose or to meet future contingencies. It is a common practice in other businesses to earmark a portion of surplus or of profits and to speak of that portion as a reserve. This leads to a more or less common notion that reserves are really surplus that the proprietors of the enterprise have chosen to dedicate to a special purpose, the dedication being a voluntary act which may be reversed. Some "reserves" set up by insurance companies are of that nature, but they are the smaller and less important ones.

It would be interesting academically to trace the origin of the custom of calling the principal liabilities of insurance companies reserves, but it would probably add little of practical value to this discussion. The usage is of long standing. It will be sufficient if it is realized that the reserves are true liabilities, though the amount of reserve necessary for certain purposes is often not susceptible of precise calculation. But this is a matter of detail which

does not change the character of the item. The amount of the liability may have to be estimated. The existence of the liability is the important fact.

Since reserves constitute by far the largest part of the liabilities of an insurer,[1] it follows that they are the principal determinant of the amount of assets that the insurer must have in order to remain solvent. But there is no "reserve fund" held to meet the obligations measured by the total reserves or those measured by any particular reserve. The total assets of the insurer are available without division to meet the total liabilities.

TYPES OF RESERVE

Reserves may be classified as liabilities or earmarked surplus, depending on whether or not they are required by statute.[2]

The reserves that fall in the first class are the present values of matured and pending claims and expenses, unearned-premium reserves, and similar obligations. The need of providing for these is in general so clear that no one could object to the requirement.

Voluntary reserves are set up by well-managed companies to enable them to meet unforeseen contingencies. Only approximately accurate predictions of probable future events can be made in reliance upon the law of large numbers and the assumption of uniformity of conditions. Therefore, unless provision is made in advance, occasional adverse fluctuations may be embarrassing. It is prudent to reserve at least part of the gain from favorable variations to meet the loss from the unfavorable.

The reserves set up by insurers may also be classified into two other groups: (1) those measuring matured obligations and (2) those measuring obligations expected to mature in the future. In the first class are (1) claim reserves, (2) claim-expense reserves, (3) reserves for taxes, (4) reserves for dividends voted, and (5) miscellaneous reserves. In the second class fall (1) the unearned-premium reserves of property and liability insurers and (2) life-and-health-insurance policy reserves.

Claim Reserves

There are two sorts of *claim* (or *loss*) *reserves* necessary to a true exhibition of a company's financial condition: (1) that for payments in the future for claims already presented whether or not determined and recognized as valid,

[1] See pp. 444–445.

[2] Classified as statutory are reserves required by a regulatory official under statutory authorization, as well as those specifically prescribed by statute.

and (2) that for claims to be presented in the future because of occurrences that have taken place before the statement date.

Under any insurance contract the claimant must prove his right to the payment promised, so that in any insurer doing an extensive business some claims are necessarily in process of adjustment on any particular date. Others may have been disputed, but the time within which suit may be brought may not have expired. Still others may be in litigation. Such claims account for part of the reserve item in all cases and in some for all of it. In addition, the provisions of some contracts, such as health and workmen's-compensation, provide that claims are to be paid in installments over a period of time. Under other contracts, such as life-insurance, the insured or the beneficiary has the option of directing that payments be so made. The present value of these payments is a liability.

In the case of life-insurance contracts, under which the benefits are payable in installments, either for a fixed period or as a life annuity, it is usual to enter the claim at the amount of its present value at the time it is presented. The original contract is then regarded as matured, and it is taken up and a new *supplementary* contract issued to the beneficiary under which the insurer agrees to pay the installments provided by the original contract. When this is done, the present value of the new contract is entered as a disbursement under claims paid and again entered as income under "consideration for supplementary contracts" either "involving life contingencies"[3] or "not involving life contingencies." The subsequent installment payments made are then reported under disbursements as payments on account of supplementary contracts. The present values of the future payments are liabilities and are reported as *reserves* for supplementary contracts, separated between those involving life contingencies and those not involving life contingencies. Thus, the total claim reserve of a life-insurance company is broken into several parts on the liability side of the annual statement, but the titles of the items make their meanings fairly clear.

The second part of the loss reserve (that for incurred but unreported losses) can only be estimated, but if the event giving rise to liability has occurred, the required payment is properly a charge against the revenues of the period during which it has occurred and not against future revenues.

Claim-expense Reserve

The claim-expense item includes provision for expenses already incurred but not fully paid, as well as for claim expenses to be incurred in the future on account of past occurrences. The nature and extent of this item vary greatly

[3] I.e., contracts under which payments are contingent on the continued life of the beneficiary.

according to the kind of insurance. In life insurance it is negligible. In fire insurance it will rarely be great since ordinarily the cost of adjusting claims involves only that of investigating the conditions at the time of the fire and the extent of the loss and damage. On the other hand, the settlement of losses under bonds is often a matter of considerable time and even litigation. Workmen's compensation losses require continuous attention to see that the medical and surgical care is best adapted to a maximum and early recovery and to prevent malingering. The terms of the liability policy call for the defense of suits against the insured, which necessarily means large expense and considerable deferment of final liquidation of many claims.

Reserve for Taxes

In general, state taxes are imposed as a percentage of premiums received during a calendar year but are not payable until after its close. At any given statement date, therefore, taxes will have accrued, and provision should be made to meet them when they become due. The same principle applies to other taxes, such as real-estate, payroll, and federal income taxes. The reserve for taxes, except federal income taxes, might be included with other reserves for expenses, but it is desirable to segregate tax liabilities since they are not expenses over which the management has control but are indirect taxes on insureds which the management is required to collect and which are passed on through premium rates. Separate reserves for federal income taxes are required since this liability is a direct deduction from surplus and not an operating or underwriting expense.

Dividends

If dividends to either insureds or stockholders have been voted, the funds required for them are not available for other purposes. They are carried as liability items. The annual-statement blanks for insurers specify liabilities for various types of dividends to insureds declared but unpaid at the statement date. Additional reserves for dividends to insureds not provided for in a dividend declaration by the board of directors are voluntary and should be carried as special surplus items.

Miscellaneous Reserves for Matured Obligations

Miscellaneous reserves for amounts due and payable at some future date are required to be set up as liabilities. Examples are commissions, including brokerage and contingent commissions; accrued salaries; unpaid bills for rent,

supplies, and similar items; and amounts retained by the insurer for account of others.

Unearned-premium Reserve

The unearned-premium reserve represents the portion of the gross premiums on contracts in force corresponding to their unexpired period. It is required in connection with insurance other than life and noncancellable health insurance. There are two reasons why such a reserve should be carried: (1) because the insurer is obligated to cover the risk for the remainder of the period, and (2) because in most such contracts the insurer and the insured have the right of cancellation, and on cancellation the unearned premium, or a large percentage of it, must be refunded. When the first reason is uppermost in mind, this reserve is sometimes called the "reinsurance" reserve, since presumably another insurer could be found to reinsure the risks for this amount. This reserve is the largest item on the liability side of statements of insurers that write primarily property insurance.

Life and Noncancellable Health-insurance Policy Reserves

Life-insurance contracts are written to cover against an increasing probability of loss but usually at a uniform or *level* premium over a long period. The excess premiums in the early years with their interest earnings constitute an accumulating addition to assets contributory to the payment of claims when they mature. The same is true of noncancellable health-insurance contracts. The reserve on these contracts might be looked upon as an unearned-premium reserve, but one gets a clearer idea of its nature if it is considered slightly differently. The whole-life contract may be taken as an example. The contract may be thought of as an exchange of two promises, each of which may be separately evaluated not only at its inception, when they are or should be of equal value, but at any future date. The insurer promises that, if the insured keeps up his premium payments, it will pay the face amount of the policy on his death. The insured promises to pay a fixed premium at each anniversary of the policy during his lifetime or for a limited period. The present value of the insurer's promise is a liability which can be calculated by the use of suitable assumptions as to future mortality and interest. The present value of the future premiums constitutes an offsetting asset which also may be valued on the same assumptions. With increase in the age of the insured the value of the liability increases and the value of the asset decreases. In other countries the two items are frequently shown separately on the respective sides of the balance sheet. Since, except at the inception of the policy, the value of the

liability exceeds that of the corresponding asset, it is the practice in this country to set up only a single item on the liability side equal to the excess of the liability over the asset.[4]

The determination of the reserve in this way is known as a determination by the *prospective* method, since the point of view is one looking to the future, comparing the value of the company's obligations with the policy assets available to meet them. Since experience rarely conforms exactly to the assumptions as to mortality and interest made in fixing premiums, the concept underlying the prospective method is the logical one to use in trying to understand the nature of these reserves.

Voluntary Reserves

Voluntary reserves are those set up by the insurer wholly on the basis of its own decision. They may be liabilities, as in the case of a reserve for depreciation of real estate owned by, or pledged to, the insurer, for the difference between the value of obligations incurred and the value as originally calculated, or for decrease in security values.[5] They may be contingency reserves, i.e., earmarked portions of surplus. Surplus is the difference between the amount of assets and the amount of liabilities plus capital, if any. Its purpose is to meet emergencies and to iron out fluctuations in experience. The purpose of a contingency reserve is the same; it is given a different name largely for psychological reasons. It carries a suggestion that it is less readily available than surplus, and it may, by reducing the amount called "surplus," forestall pressure for distribution as dividends or give an impression of smaller accumulated profits.

CALCULATING RESERVES

Except for contingency reserves, the determination of the required amount of any reserve is a matter of direct or indirect inventory; that is, a list of the items in respect of which reserves are needed must be prepared, appropriate values must be found for each item, and the total summed. The work may be done from book entries and files, card records, or electronically recorded data. The methods of calculating the reserve differ according to the kind of reserve and the type of records kept by the insurers. In the following paragraphs the more common methods are briefly outlined.

[4] More details on this calculation will be presented on pp. 441–442.

[5] See p. 456. "Security fluctuation reserves" of property and liability insurers are a part of surplus, though they may be classified as liabilities in some cases.

Loss Reserves

All insurers keep some form of loss or claim register or file in which claims are entered as they are received, with various particulars adapted to the individual insurer's methods. Almost always the register shows the final disposition of the case. The register is supplemented by individual claim files and sometimes by card records. From this source the list of unpaid claims is obtained.

In life insurance, where the face of all policies is payable at death or on survival and where the claim procedure is so simple that relatively few cases remain unsettled for any appreciable time, the list may be taken from the register and totaled. That part of the reserve representing the present value of amounts due in the future on supplementary contracts, whether involving life contingencies or not, is a rather simple matter of calculation in the actuarial department on the basis of standard interest and mortality tables.

In fire insurance, the amount of loss for which the insurer is liable must be ascertained by investigation and negotiation. This process takes time, so that more claims will be open at any given date than in a corresponding volume of life insurance. The individual value of each must be determined for the reserve inventory. Sometimes preliminary estimates are entered on the claim register and changed as additional information is obtained. Even when these entries are not made, the estimates appear in the claim files. Such estimates represent the best judgment of the adjusters in the light of all the facts known to them at the time they are made. It is customary to revise the estimate on each claim jacket as new information is received and, in some insurers, to review periodically all open files and fix new estimates. Once the amount of the loss is agreed upon by insurer and insured, that amount becomes the reserve until the loss is paid.

This method of *individual estimates* might be used in any line of insurance. Its greatest weakness is the possibility of overoptimism on the part of claim estimators. Sometimes, when an insurer's finances have been at a low ebb and the statement is likely to show little if any surplus, the "wish is father to the thought," and reserves are consciously or unconsciously underestimated. Such conditions have led to the prescription by statute of methods of calculation, particularly for liability and workmen's-compensation claim reserves.

Where the number of claims outstanding at a given time is small and there is considerable variation in the amounts of the individual claims, the individual-estimate method appears to be the most economical if not the only available one. It is almost exclusively used in fire, marine, and allied lines of insurance, and in such lines as glass, burglary and theft, boiler and machinery, property damage liability other than automobile, and fidelity and surety.

As a check against overoptimism, the annual-statement blanks prescribed

by the insurance commissioners contain schedules in which, for certain lines of insurance, estimates at the end of prior years are compared with the subsequent payments and with revised estimates on claims still open. If these schedules show persistent underestimation of requirements, there is a presumption that the reserves in the present statements are inadequate, and the commissioners act accordingly, usually making an examination of the insurer and determining what are proper reserves. If the company is still solvent on the proper reserve basis, the correction usually results in better estimates in the future.

Conservatism or overpessimism may result in reserves that are higher than necessary. While exaggeration of liabilities is on the side of safety, it makes for an inaccurate statement and, by inflating the loss figure, may be used as a basis for unreasonable premium rates. Comparison of estimates with final payments and detailed examinations will also reveal any tendency or condition of this sort.

Where the number of open claims is large, the individual-estimate method is burdensome, and short cuts are sought. One such short cut, readily available when there is not too great variation in the size of individual claims, is the use of *average values*. The insurer's experience over a past period is examined, and the amounts of losses of particular types are tabulated and averaged. The averages so derived are then multiplied by the number of claims of these types outstanding at statement date, and the product, less amounts already paid, taken as the reserve. The experience period used to determine the average values should be broken into several subperiods, and averages worked out for each in order to determine whether there is any tendency toward increase or decrease in the average size of claims. If so, the trend must be observed and probably (especially if the tendency is to increase) be projected in order to get an adequate average. This method is particularly suitable for the calculation of reserves for automobile-physical-damage or for automobile-property-damage liability insurance.

A variant of this method is the *notice-average* method. The average cost per notice of accident is multiplied by the number of notices received during the past year. From this total the amount already paid in respect of any such notices is deducted, and the balance is the reserve, as of the end of the year.

For valuing such benefits as life pensions granted to the permanently disabled under some compensation laws, or widows' pensions, which involve both life contingencies and contingencies of remarriage, use is made of mortality and remarriage tables which indicate the probabilities of survival and of remarriage. This is the *tabular-value* method.

In the early history of bodily-injury liability insurance, reserves were set up by the individual-estimate method. The estimators of some companies proved too optimistic, producing inadequate reserves. This led to statutory enact-

ments prescribing other methods. The average-value method, the first tried, also proved unsatisfactory. The present method, as prescribed by the annual-statement blank, uses individual estimates of loss and loss-expense reserves for contracts written during the fourth or earlier years preceding the date of the statement, subject to a specified suit-value check. Suits pending under contracts dating from the fourth and fifth years are assigned an average value of $850; during the sixth to eighth years inclusive, $1,000; and during the ninth and later years, $1,500. The reserve in respect of these years is the total of the individual estimates of losses and loss expense outstanding or the total produced by using the suit values, whichever is greater. For the 3 years preceding the date of the statement the individual-estimate method is used, subject to a loss-ratio check. The reserve in respect of each of these 3 years is the total of the individual estimates of losses and loss expense outstanding or 60 per cent of the premium earned on the contracts written or renewed during these years less losses and loss expense already paid, whichever is greater, to which the insurer *may* add a voluntary reserve.

The formula method is also prescribed for workmen's-compensation loss reserves, the percentage of earned premiums to be used being 65. The average value per suit is not applicable to workmen's-compensation losses since practically all cases are settled without resort to the courts. The reserve for open cases under policies issued more than 3 years prior to the statement date is the total of their present values as determined by actuarial calculation. The status of a workmen's-compensation case 2 years or more after the accident is usually sufficiently certain to permit accurate valuation. As in the case of liability insurance, if the total of the estimated cost of individual cases is in excess of the reserve produced by the formula, the former must be used.

At the June, 1968 meeting of the National Association of Insurance Commissioners a more flexible method for regulating liability and compensation reserves was approved, but minimum reserves for the most recent three years are still to be determined by a formula method.

Where the claim reserve is not calculated by prescribed formulas, as it is in liability and workmen's compensation insurance, the reserve for unreported cases, excluding bonding, is made up by examining past experience and adjusting this experience for such elements as increased exposure and changes in average claim cost. For bonding business, the New York Insurance Law requires that the reserve for unreported cases be not less than 10 per cent of the net premiums on business in force for fidelity and not less than 5 per cent for surety.

Variation in methods is a practical necessity, but the objective is always the same, i.e., to arrive at a figure that fairly represents what the insurer may reasonably expect to be called upon to pay in the future for losses and loss expense arising out of events that have occurred prior to the statement date.

Loss-expense Reserve

The loss-expense reserve for most lines of insurance is usually found by determining from accounting records the ratio of the amount paid for loss expense to that paid for losses. For known losses, this ratio is usually discounted to allow for expenses already incurred, but is applied in full to that part of the reserve representing delayed losses.

UNEARNED-PREMIUM RESERVE IN PROPERTY AND LIABILITY INSURANCE

The unearned-premium reserve is determined by tabulating the premiums on the business in force, according to year or month of issue and term. It is customary to assume that the business issued in any period was uniformly distributed over that period, which is equivalent to its being concentrated at its mid-point. Thus, annual policies issued during the calendar year at the end of which the reserve is computed are assumed to have been in force, on the average, one-half their term and to have one-half to run, so that 50 per cent of the premiums upon them is unearned. On 3-year policies of the same year, one-sixth is assumed to have been earned and five-sixths to remain unearned. Similarly for other years of issue and durations. The assumptions conform reasonably closely to fact. If the tabulation is by months, policies issued in July to run 1 year will, on the average, have earned 5½ months' premiums (eleven twenty-fourths of the annual premium) by December 31, and thirteen twenty-fourths of the annual premiums will be earned at that date.

POLICY RESERVES IN LIFE AND HEALTH INSURANCE

In the earlier discussion of policy reserves it was noted that the reserve on an outstanding contract of life insurance can be calculated as the difference between the present value of the insurer's promise and the present value of future premiums. Under the net-level-reserve approach the expected expenses (not benefits to insureds) are assumed to be matched by the expense loading in the premiums in amount and timing. Consequently the expenses and the expense loading are ignored in the calculation. The reserve then becomes the present value of future benefits under the contract less the present value of future *net* premiums.

To illustrate, take a straight-life-insurance contract for $1,000, issued at age 30. If mortality rates are assumed to be those in the 1958 CSO mortality table and the interest rate to be 3 per cent, the net level annual premium is $13.47. Ten years later, at age 40, the value of the insurer's promise to pay $1,000 when the insured dies is $406.58, the net single premium for whole

life insurance at that age. The value, at the same date, of the net premiums that are to be received annually by the insurer throughout the future lifetime of the insured is $13.47 times the present value of $1 payable for the remainder of the insured's life, which is $20.37. The difference between these two present values ($406.58 — $274.39) is the insurer's net liability or reserve of $132.19.

The net-level-premium reserve is a conservative measure of the insurer's liability because the insurer incurs most of its expenses in the first year. The expense loading in the second and following years will be more than sufficient to cover the expenses incurred in those years. Under modified reserve systems that are permitted by law but are too complicated to explain in an introductory text, the insurer is permitted to assume that in the future it can use some of the expense loading in future premiums to pay benefits. The present value of future benefits remains the same but the present value of the future modified net premiums is higher than the present value of the future net premiums (unless both are zero). Consequently the modified reserve is less than the net-level reserve until the premium period has ended.

The methods used in calculating these reserves differ among the companies mainly according to size, methods suitable to a small company being too cumbrous for a large one, and conversely, short cuts that have enormous labor for a large company having little advantage when the volume of business is small. In most cases two assumptions are made: (1) that the business is uniformly distributed over the year so that mean reserves (the average of the reserves at the beginning and the end of the year) may be used at any statement date with respect to the policies issued in any preceding 12 months' period ending on the same day (December 31, June 30, etc.), and (2) that all premiums are paid annually in advance. The first assumption is realized with close approximation in practice. The second is not. At any statement date there are some policies for which the current premium is past due, i.e., the grace period has not yet expired. Also, the premiums on many policies are payable semiannually, quarterly, or monthly, and at the statement date there may be a semiannual or one or more quarterly or monthly premiums not yet due. These are "deferred premiums." A precise reserve computation taking account of the exact status of each policy would involve an impossible amount of labor. To offset the excess reserve set up by the assumption as to payment, an entry is made on the asset side of the statement of the net *deferred and uncollected* premiums.

In most states the statutory minimum basis for reserves on life-insurance policies on standard lives is the 1958 CSO table of mortality with an interest assumption of 3 or 3½ per cent, though many companies use 2¼ or 2½ per cent and, as a result, maintain higher reserves. Other more suitable tables are prescribed for determining reserves on industrial and substandard policies and on annuities.

Expense and Contingency Reserves

The various expense and tax liabilities are similar to corresponding items in the balance sheets of other business concerns. No special technique is necessary to determine them. Nor is there such uniformity of procedure in fixing contingency reserves, whether for underwriting or investment contingencies, as to warrant describing any particular procedure as typical.[6]

RELATIVE IMPORTANCE OF RESERVES

The several types of reserves discussed in this chapter are not of equal importance, but taken together they constitute by far the major part of the liabilities against which the assets are held. Tables 28–1, 28–2, and 28–3 show the major items of liabilities (reserves) and the percentage each is of the total liabilities. The capital and surplus are, of course, not liabilities but are included in order to bring a total in each table equal to the total of the corresponding assets. This arrangement also permits a percentage comparison of these items with the liabilities.

Tables 28–1 and 28–2 show aggregate figures for two types of property and liability insurers; Table 28–3 presents data for all types of life insurers combined. Differences in types of insurer, their major fields of operation, and their operating policies will cause the percentages to differ for individual insurers. Some mutual companies and reciprocal exchanges have guaranty funds corresponding to the capital of stock companies. Others do not and show only one surplus item. Alien companies are required to make a deposit with the state through which they enter as quasi-capital of the United States branch.

ACCURACY OF STATUTORY RESERVES

Statutory reserves are often *redundant*, i.e., larger than the amount necessary to meet the obligations that they are supposed to measure.

This is particularly true of the unearned-premium reserve, which is based on the assumption that the losses and expenses that premiums are expected to meet are spread evenly through the term of the contract. Actually, some expenses, such as agents' commissions and those of issuing and recording the policy, are met at the inception of the contract. Further, the premium rate usually is fixed in contemplation of a margin between disbursements and premium income. Consequently, the insurer needs, roughly, only about 50 to 65 per cent of the premiums to meet obligations after the payment of initial

[6] But see p. 456.

Table 28–1 BALANCE SHEET, 792 UNITED STATES STOCK PROPERTY AND LIABILITY INSURERS, December 31, 1966
(In billions of dollars)

Assets			Liabilities		
	Amount	Per cent		Amount	Per cent
Government bonds	$12.6	40.5	Loss and loss adjustment expense	$ 8.7	28.1
Other bonds	1.7	5.5	Unearned premium reserves	8.4	27.1
Mortgages	0.1	0.2	Other liabilities	1.9	6.1
Stocks	11.8	38.0	Total	$19.0	61.3
Real estate	0.4	1.4	**Capital and Surplus**		
Premium balances	2.3	7.5	Capital	$ 1.3	4.2
Cash	1.0	3.1	Net surplus	8.4	27.1
Other	1.2	3.8	Voluntary reserves	2.3	7.4
			Total capital and surplus	$12.0	38.7
Total	$31.0	100.0	Total	$31.0	100.0

Source: "Best's Aggregates and Averages, 1967," Alfred M. Best Co., New York, 1967, p. 54.

Table 28–2 BALANCE SHEET, 336 UNITED STATES MUTUAL PROPERTY AND LIABILITY INSURERS, December 31, 1966
(In billions of dollars)

Assets			Liabilities		
	Amount	Per cent		Amount	Per cent
Government bonds	$5.0	52.8	Loss and loss adjustment expense	$3.4	35.8
Other bonds	1.4	14.7	Unearned premium reserves	2.3	24.2
Mortgages	0.1	1.0	Other liabilities	0.9	9.5
Stocks	1.8	18.7	Total	$6.6	69.5
Real estate	0.2	2.3	**Capital and Surplus**		
Premium balances	0.5	4.8	Guaranty funds	$0.1	1.1
Cash	0.3	3.0	Net surplus	2.5	26.3
Other	0.3	2.7	Voluntary reserves	0.3	3.2
			Total capital and surplus	$2.9	30.5
Total	$9.5	100.0	Total	$9.5	100.0

Source: "Best's Aggregates and Averages, 1967," Alfred M. Best Co., New York, 1967, p. 152.

Table 28–3 BALANCE SHEET, UNITED STATES LIFE INSURERS, December 31, 1966

(In billions of dollars)

Assets			Liabilities		
	Amount	Per cent		Amount	Per cent
Government bonds	$ 10.6	6.4	Policy reserves	$134.5	80.5
Other bonds	61.3	36.7	Policy dividend accumulations	4.6	2.8
Mortgages	64.6	38.7	Policy dividend reserve	2.9	1.8
Stocks	8.8	5.2	Other liabilities	10.2	6.1
Real estate	4.9	2.9	Total liabilities	$152.2	91.1
Policy loans	9.1	5.5	**Capital and Surplus**		
Due and deferred premiums	3.7	2.2	Capital	$ 1.5	0.9
Cash	1.5	0.9	Unassigned surplus[1]	10.7	6.4
Other	2.6	1.6	Special surplus funds[2]	2.6	1.6
			Total capital and surplus	$ 14.8	8.9
Total	$167.0	100.0	Total	$167.0	100.0

[1] Includes paid-in and contributed surplus.

[2] Held for contingencies such as an unexpected rise in mortality rates or drop in security values.

Source: "1967 Life Insurance Fact Book," Institute of Life Insurance, New York, 1967, pp. 58, 62, 63, 88.

expenses. There is an *equity* of some 35 to 50 per cent in the unearned-premium reserve.[7]

It is true that the insurer, if it canceled all its outstanding business, would be required to return the total unearned premiums and hence might conceivably incur obligations equal to the entire unearned-premium reserve. But such a possibility is remote—the usual method of retiring from business is to reinsure outstanding contracts, which can be done at a price seldom higher than the 50 to 65 per cent of unearned premiums and often lower.

As to life insurance, it has already been noted that the net-level-reserve system is a conservative approach to reserve calculation. The reserves may also be greater because the insurer uses a lower interest-rate assumption than is realistic.

These excess reserves do not imply excessive premium charges. They do require the insurer to have sufficient assets to cover them and other liabilities

[7] Less, however, the amount of income taxes extinguished by deducting these advance expenses.

and hence make for greater safety than would be the case if reserves were strictly accurate. At the same time, they make rather onerous the financing of a new insurer or the financing of an increasing volume of business by an established insurer. Sufficient assets must be available, after meeting certain expenses in advance, to finance the excess reserves as well as the surplus necessary to a going concern. An insurer could, in fact, write so much profitable business that it would become technically insolvent.

This situation tends to restrict the facilities of the market in times of general business expansion, and on occasion to make the market so tight that the needs of business for insurance cannot be met. On the other hand, when general business is depressed and insurers are competing eagerly, it puts a restraining hand on the offering of too great inducements and on the organizing of new insurers that are not needed.

QUESTIONS

1 "The reserves of insurance companies are invested in high-grade securities." Comment.
2 "Insureds are protected by separate reserve funds maintained to enable insurers to meet their various obligations." Comment.
3 What is the basic purpose of the reserve?
4 Why is it necessary that certain insurers set up unearned-premium reserves?
5 Distinguish between loss reserves and loss-expense reserves.
6 Distinguish between unearned-premium reserves and policy reserves.
7 How would the twentieth terminal reserve on a 20-pay life-insurance policy issued at age 20 compare with the tenth terminal reserve on a 10-pay life-insurance policy issued at age 30?
8 How could you determine whether an insurer was underestimating or overestimating its workmen's-compensation loss reserves?
9 Which of the reserve types would be most important for an insurer specializing in property insurance? Liability insurance? Life insurance?
10 To what extent do reserves, as usually set up, measure with precision the amount necessary to cover the probable disbursements of an insurer in connection with the obligations to which they relate?

29
INSURANCE FINANCE

In addition to providing protection for their insureds, insurers are important financial institutions. The way in which they manage their funds is important not only to their insureds and their stockholders, if any, but also to society. This chapter will document the statement that insurers are important financial institutions, analyze their sources of funds for investment, describe their investment objectives and portfolios, and comment briefly on their distribution of earnings.

IMPORTANCE OF INSURERS AS FINANCIAL INSTITUTIONS

The importance of insurers as financial institutions can be illustrated in many ways, two of which will be presented here. First, insurers are among the most important sources of funds in the United States money and capital markets. As indicated in Table 29–1, life insurers currently provide about 10 per cent of the funds used in these markets. Only commercial banks supply more funds, and they tend to specialize in short-term debt. Property and liability insurers play a much less important role than life insurers for reasons to be given below, but their contribution is still considerable. Noninsured pension funds, which are insurers from the viewpoint of the covered employees and which closely resemble insured pension plans in their objective and operation, have been providing an increasing proportion of the funds for these markets. The proportion provided by life insurers, although larger, is decreasing.

Second, at the close of 1966 life insurers controlled assets worth more than $167 billion. At year-end, 1954, they owned only half this amount. During 1966 life insurers increased their assets by about $8 billion and their new investments by about $37 billion. The new investments exceeded the net increase in assets because of reinvestments, exchanges, replacements, and short-term security purchases.[1] At present life insurers hold over one-fifth

[1] "Life Insurance Fact Book, 1967," pp. 62, 65.

Table 29–1 SOURCES OF FUNDS IN THE UNITED STATES MONEY AND CAPITAL MARKETS, 1957, 1962, and 1967
(In billions of dollars)

	1957	1962	1967*
Life insurers	$ 4.7	$ 5.7	$ 8.6
Savings and loan associations	4.9	10.3	4.7
Mutual savings banks	1.7	3.3	3.0
Noninsured pension funds	2.9	4.0	6.5
Commercial banks	4.5	18.4	18.0
Federal reserve banks	−0.7	1.9	4.5
State and local funds	1.9	3.6	7.0
U.S. investment accounts	1.2	1.0	6.5
Federal loan agencies	1.6	0.9	3.5
Nonfinancial corporations	2.5	4.7	6.5
Property and liability insurers	0.7	1.2	0.8
Individuals and others	8.1	7.5	13.5
Total sources	$34.1	$62.6	$83.1

* Estimated.
Note: The dollar amounts in this table, which measure the *net* changes in ownership, are matched by dollar uses of funds which measure the *net* changes in outstanding loans and securities. These uses include corporate bonds, corporate stocks, government issues of various sorts, mortgages, business loans, consumer loans, and other credit.
Source: James J. O'Leary, "The 1967 Money Tree," *The Spectator*, vol. 175, no. 1 (January, 1967), p. 25.

of the nation's total mortgage debt and a substantial portion of the private business bonds outstanding. Many of these bonds were acquired through direct placements; i.e., through direct negotiation with the borrowers instead of by purchasing publicly offered bonds.

At year-end, 1966, property and liability insurers had assets valued at about $41 billion.[2] The assets of these insurers have also grown steadily. In 1954 they also owned about half of this amount. For reasons to be explained below, their asset values are more subject to market fluctuations than are those of life insurers.

SOURCES OF FUNDS

Insurers receive their funds for investment from several sources, the most important of which are (1) their liabilities (primarily the reserves described in Chapter 28), (2) capital and paid-in surplus, and (3) their retained earnings, which are a product of their past operations and dividend policies.

[2] "Insurance Facts, 1967," p. 16.

The relative importance of these three sources of funds for life insurers, stock property and liability insurers, and mutual property and liability insurers is evident from the balance sheets in Tables 28–1, 28–2, and 28–3. Policy reserves provide most of the funds for life insurers. Loss reserves and unearned-premium reserves are important sources of investment funds for stock property and liability insurers, but these insurers have also retained in their business a substantial share of their past earnings. Mutual property and liability insurers also obtain investment monies through reserves and retained earnings, but retained earnings are a slightly less important source of funds for them than for stock insurers. A stock insurer's capital, representing the par value received for stock and its paid-in surplus, which is the amount in excess of par value received for its stock, constitutes a minor source of funds, except for new insurers. The guaranty fund provided by the organizers of new mutual insurers is an important source only in the early years. Indeed, it is often retired as the insurer matures.

Reserves

The major reserves established by insurers are the policy reserves, unearned-premium reserves, and loss and loss-expense reserves described in Chapter 28. These reserves are established because insurers receive premiums in advance, subject only to the delay incident to extension of short-term credit, in exchange for obligations to pay losses and furnish services in the future—obligations that may run into the far-distant future. The pure assessment mutual may defer assessments until after losses have occurred, but even here advance assessments are often made in order to be able to meet expenses and losses as they occur.

The extent of the time lag between receipt of premiums and meeting obligations to insureds and third parties varies greatly between kinds of insurance, methods of premium payment, and contract periods. Loss payments under fire-insurance contracts are spread over the years for which they are written and, except when involved in litigation, are usually completed shortly after expiration of policy periods. Payment of a loss under a single-premium life-insurance contract taken out at age 25 might be made 75 years later. Liability losses and loss expenses are paid over a period of several years following receipt of premiums. Periodic payments under health insurance contracts or workmen's-compensation-insurance contracts may continue for the life of the recipient or for varying periods dependent on contract provisions, workmen's compensation laws, and duration of disability. Recently developed plans for paying premiums in installments reduce the time lag between premium payments and insurer performance.

Expenses of operation, other than those closely associated with losses, are

largely met immediately on, or shortly after, payment of the premiums to which they are related. Where policies are issued and premiums collected by an agent, he deducts his commission before remitting to the insurer. Commissions to others are paid with little or no delay. Expenses incident to issuing a policy are paid at the time of issuance. Others are distributed through the life of the contracts to which they relate.

All of this results in the insurer holding funds that are depleted by payment of losses and expenses and augmented by premium receipts. In times of increasing volume of business, the amount in this reservoir of funds will generally increase; in times of decreasing business, the amount will decrease. But there will be a continuing amount available for investment, just as water-supply reservoirs maintain a supply of water through variations in rainfall and use. In some cases the insurer relies on investment earnings to meet losses in part.

Retained Earnings

Surplus to policyholders is the amount by which the assets of an insurer exceed its liabilities. It protects insureds and third parties against any deficiency in provision for meeting the insurer's obligations. Such deficiency may arise from inadequate premiums, inadequate reserves, or decrease in the value of assets.

Surplus to policyholders includes the paid-in capital of a stock insurer and any capital or guaranty funds of a mutual as well as paid-in surplus, "special," "voluntary," or "contingency" reserves (earmarked surplus accounts, not liability accounts), and net or unassigned surplus.

Property and Liability Insurance. The retained earnings of a property and liability insurer represent the earnings of past years that have been plowed back into the business instead of being out as dividends to stockholders or policyholders. These earnings result from both the underwriting and the investment activities of the insurer.

In a given year the underwriting profit of a property and liability insurer can be computed as follows: [3]

[3] Except in connection with expenses where the adjustment is incomplete, insurance accounting is on an accrual basis, not a cash basis. The adjustments are as follows:

Premiums earned	=	Premiums written minus increase in the unearned-premium reserve.
Losses incurred	=	Losses paid plus increase in the loss reserve.
Expenses incurred	=	Expenses paid plus some adjustments for prepaid and unpaid expenses.

Premiums earned
− Losses incurred
− Expenses incurred
= Statutory underwriting profit

The net investment gain is computed as follows:

Investment income (Interest, dividends, and rents)
− Investment expenses
+ Net realized capital gains
= Net investment gain

In most years both the net investment income and the net investment gain of stock insurers exceed their underwriting profit.

The statutory net income is the sum of the following items:

Statutory underwriting income
+ Net investment gain
+ Other income (usually minor)
− Dividends to policyholders
− Income taxes
= Statutory net income

A simplified but instructive and not too unrealistic formula for computing the increase in retained earnings is the following:

Statutory net income
+ Unrealized capital gains
− Dividends to stockholders
= Increase in retained earnings

Unrealized capital gains increase retained earnings because, as will be explained below, insurers value their common-stock investments at their market value.

Many observers argue that this calculation understates the true underwriting income (and consequently the increase in retained earnings) of an insurer if its unearned-premium reserve is increasing for the same reasons that the unearned-premium reserve was stated on p. 443 to be redundant. They would add to the statutory underwriting income 35 to 40 per cent of the increase in the unearned-premium reserve less the additional income taxes that this would create. If the unearned-premium reserve is decreasing, the opposite correction would be necessary; i.e., the statutory underwriting income would be decreased by the same per cent of the decrease in the unearned-premium reserve. According to this school of thought, the statutory underwriting

income is understated when an insurer is rapidly increasing its premium volume; it is overstated when the premium volume is declining.[4]

Both stock and mutual insurers try to maintain the same level of dividends, whether to stockholders or to insureds, from year to year with changes, if any, only in the form of increases.[5] It is the general policy of stock companies to keep dividends to stockholders well within net investment income (not including changes in market value), which is much more stable than underwriting profits (premiums less the losses and expenses they are designed to cover). By allowing underwriting profits to increase surplus in good years, the surplus account is prepared to absorb losses in poor years. Mutuals generally pay dividends to insureds from underwriting "profits" and let investment earnings go to surplus.

Life and Health Insurance. Unlike property and liability insurers, life insurers rely upon investment income to meet a substantial share of their losses and expenses. Consequently these insurers do not distinguish between their underwriting profit and their investment profit. Instead their net gain from operations after dividends to insureds is computed basically as follows:

Income:
  Premiums
  Net investment income
    (Interest, dividends, and rents less investment expense)
  Other income
− Deductions from income:
  Benefit payments
  Increase in policy reserves
  Operating expenses and taxes
= Net gain from operations
− Dividends to policyholders
− Federal income taxes
= Net gain after dividends and income taxes

[4] Another way to compute the statutory underwriting profit as a per cent of the premiums earned is as follows:

$$\frac{\text{Statutory underwriting profit}}{\text{Premiums earned}} = 1 - \frac{\text{Losses incurred}}{\text{Premiums earned}} - \frac{\text{Expenses incurred}}{\text{Premiums earned}}$$

To correct for the redundancy in the increase in the unearned-premium reserve, some analysts divide the expenses incurred by the premiums written. The assumption underlying this adjustment is that expenses incurred bear a stronger relationship to premiums written than to premiums earned. If the unearned-premium reserve is increasing, premiums written will exceed premiums earned and the adjusted statutory income will exceed the statutory income.

[5] This is not to say that they are always successful; shifts in underwriting or investment experience may require decrease, or even elimination, of dividends.

The increase in retained earnings is computed as follows:

Net gain after dividends and income taxes
+ Net realized and unrealized capital gains
− Dividends to stockholders
= Increase in retained earnings

Investment income in 1966 was equal to 28 per cent of the premium income of life insurers but was less than 5 per cent of the premiums earned of property and liability insurers. The reason for this difference is the substantial policy reserves associated with outstanding life-insurance and long-term health-insurance contracts.

Capital gains are a much less important factor for life and health insurers than for property and liability insurers because, for reasons to be explained below, they invest a much smaller proportion of their assets in common stock.

As in property and liability insurance, the method of computing the net gain from operations tends to understate the true net gain. In life insurance this understatement occurs because the heavy first-year expenses are not covered by the expense loading in the first-year premium, but the expenses incurred in later years are less than the expense loading in later premiums. To some extent this understatement has been adjusted by the use of the modified-reserve systems described on p. 442, but the adjustment is not complete.

Like their counterparts in property and liability insurance, participating stock life insurers try to maintain their dividend scale or to increase dividends, but they are not subject to fluctuations in losses as great as those of property and liability insurers, and consequently their surpluses are much lower in proportion to their volume of business than is the case with such insurers. Since a much larger proportion of their income is attributable to investment earnings than is that of property and liability insurers, their ability to pay dividends is more closely related to investment yields. Dividends to stockholders tend to be low, as life insurers use retained earnings to finance part of their growth.

INVESTMENTS

Investment Objectives and Portfolios

Property and liability insurers issue for the most part short-term contracts; their losses vary with changes in the Consumers' Price Index; and they are subject to catastrophe losses, particularly in property insurance. To the

extent that they emphasize liability insurance, large losses may arise within a brief interval of time, but these losses may be payable in installments over a considerable period of time; e.g., an insurer doing an extensive workmen's-compensation-insurance business may become involved in a single catastrophe that will cause losses running into large amounts spread, however, over a term of years. Although property and liability insurers do not consider investment income directly in establishing premium rates, these insurers need a satisfactory yield to provide dividends for stockholders or policyholders and to increase retained earnings.

Tables 28–1 and 28–2 illustrate the application of these principles. The two most common investments are bonds that are highly liquid and stocks in well-known corporations that are readily marketable and provide an opportunity for capital appreciation. These two tables also reveal the difference in philosophies between the average stock insurer and the average mutual insurer. Mutual insurers tend to be more conservative, perhaps because many mutuals are small operations and because their policyholders' surplus tends to be a smaller percentage of their liabilities than the ratio for stock insurers.

These two tables (and Table 28–3) do not reveal the differences among individual insurers. For example, one stock insurer emphasizes common stocks; another stock insurer with a similar underwriting philosophy specializes in municipal bonds because of special expertise in this area and tax considerations.

Life insurers issue long-term contracts promising (usually) fixed-dollar benefits. They seldom face an excessive loss from a single occurrence. Even the influenza epidemic of 1918 did not, in most cases, call for cash in excess of funds readily realized without sale of investments. Furthermore, these insurers use an assumed interest rate in their premium, reserve, and cash-value computations. Consequently their investment objectives are security, stability of value, and yield. Liquidity is of minor importance. Their yield must equal or exceed their assumed rate of return. Because their obligations are long-term and their liquidity needs are small, they can, and should, seek long-time or semipermanent investments properly spaced as to maturities to provide a fairly even flow of funds for reinvestment or for other purposes. This is particularly true if the trend of the interest rate is downward, for then a short-term investment must soon be replaced at a lower yield. Investment expense is also reduced if it is not necessary to change investments too frequently.

In accordance with these objectives, the investment portfolios of life insurers, as shown in Table 28–3, consist mainly of long-term bonds, but mortgages are also an important component. Stocks are a relatively small part of the total portfolio because of their fluctuating value.

Valuation of Assets

Certain assets of insurers are not recognized as such in official accounting. The most important is the good will built up by a sales organization, an asset that does not lend itself to accurate valuation and that loses its value on liquidation. Premiums on insurance contracts effective more than 3 months before the date of the statement, and such property as furniture, fixtures, and supplies, are also excluded.

The assets recognized by regulatory authorities as a proper part of the resources of an insurer are called *admitted assets.*

Real Estate. An insurer needs only the real estate required for office accommodation, and the intent of the law in most states is to restrict its holdings to this limit, with reasonable allowance for expansion. But any insurer may find it necessary from time to time to take over real estate by foreclosure of mortgages, or in liquidation of debts arising out of its business. These items are usually carried at the market value as determined by appraisal. Life insurers are permitted, subject to limitations, to invest for income in certain kinds of real estate.

Mortgage Loans and Collateral Loans. If properly secured, loans are always carried at the amount loaned. If the security is not up to that standard, the value is reduced or eliminated.

Stocks. Stocks are valued at market, but because of the fluctuating character of their market value, a "reserve" item is often carried in the surplus account to provide for possible decreases in value.

Bonds. Bonds in good standing, i.e., amply secured and not in default as to principal or interest, are valued by the process of amortization or accrual of discount, depending on whether they were purchased at a price above or below par. Their value gradually approaches par until it reaches par at maturity.

Bonds *not* in good standing are valued on the basis of whatever market or other pertinent information is available. The National Association of Insurance Commissioners publishes annually values of such bonds and of unlisted securities.

Other Assets. Other assets are cash, open accounts, premiums in course of collection, and minor items. They are usually valued at par, with suitable deductions for uncollectible items.

Changes in Value of Assets. Changes in the value of assets give rise to bookkeeping profits or losses, and on sale of the assets to realized profits or losses. Over a long period realized profits may be an important part of the net income of a well-managed insurer. In crises, a vulnerable investment portfolio may be the cause of an insurer going into liquidation or being taken over for rehabilitation.

Life insurers are required to build up a *mandatory security-valuation reserve,* as a liability, amounting to 1 per cent of the total value of amortizable bonds and to 20 per cent of the value of stocks.

Insurers Not Trustees

While insurers are held to strict accountability for the stewardship of funds held for the purpose of meeting their obligations, they are not *trustees,* nor are their assets *trust funds.* The assets are the property of the insurer, but not property that it may handle or dispose of as it pleases. Its responsibilities are determined by its insurance contracts, by law, and by regulations of governmental authorities. The regulation of insurer investments will be discussed in Chapter 35.

SURPLUS—DISTRIBUTION OF EARNINGS

The surplus of an insurer is the balancing figure of its annual statement. It is the excess of assets over the sum of the liabilities and the capital, if any. The ownership of the surplus depends on the type of insurer and on the terms of its policy contracts. Some comments have been made earlier in this chapter about the distribution of this surplus to policyholders and dividends, but the subject is important enough to justify more extended comment.

In a mutual insurer the surplus is the property of the body of insureds, although sometimes mutual life-insurance companies have contracts in force which provide that the insured shall not share in the surplus of the company. In whomever ownership of the surplus lies, control of its disposition rests with the board of directors (or trustees) as managers of the insurer, subject to its policy contracts.

The present practice of mutual companies is to distribute annually to

insureds such part of earnings as may be deemed proper, having regard to security of the insurer and equity among classes of insureds. Methods of making the apportionment differ so greatly, according to the kind of bus ness, and in some cases involve such detail that no complete discussion is possible here. In property and liability insurance, however, it is common practice to return to all insureds the same per cent of their premium. In life insurance, the dividend apportionment is far more complicated. Usually an attempt is made to return to each insured his fair share of the contribution to surplus from each of three separate sources: mortality savings, excess investment earnings, and expense savings. It is the usual practice to time the distribution to coincide with the next premium-due date, which facilitates payment by deduction from the premium due and also develops the maximum competitive advantage of the mutual.

The policy contracts of mutual insurers usually make the methods of distribution adopted by the board binding on the insured. About 1900 when the dividend periods of many life-insurance contracts ended, and dividends were much smaller than the estimates made when the policies were sold, several disgruntled insureds brought suit for accounting, but the courts did not sustain them. More recently a former insured of a large mutual casualty-insurance company brought suit for his pro-rata share of the surplus earned during his membership but did not succeed. The court held that the amount of surplus required from time to time was a business question to be decided by the directors, in which, in the absence of bad faith, the court would not interfere.[6]

Sometimes stock companies give their insureds by contract provision a right to share in the distribution of the company's earnings. In that case, questions may arise as to the respective rights of stockholders and insureds.

Where the earnings are the exclusive property of the stockholders, the considerations that determine the time and manner of their distribution are the same as with other stock corporations, save for the necessity of maintaining a suitable surplus to protect against fluctuations and catastrophe.

QUESTIONS

1 How do insurers rate as sources of funds for the money and the capital markets?
2 From what sources do insurers obtain their funds for investment?
3 Compare "surplus to policyholders" with "surplus."

[6] *White Fuel Corporation* v. *Liberty Mutual Ins. Co.*, 313 Mass. 165, 46 N.E. 2nd 548 (1943). The regulation of dividends by state insurance departments is discussed on pp. 545–546.

4 Compare, by type, the distribution of investments of life-insurance companies and of those of other insurers. What are the reasons for the differences?
5 How do life insurers compare with property and liability insurers with respect to policyholders' surplus ratio? Investment income relative to premium income? Investment income relative to underwriting profit? Dividend-distribution formulas?
6 What is the difference between statutory underwriting profit and adjusted statutory underwriting profit?
7 Why are insurers permitted to value bonds in good standing by amortization (or accrual of discount) rather than by market price?
8 "Insurers are quasi-trustees." Comment.

30
UNDERWRITING

The term *underwriting* and its associated term *underwriter* are used loosely. In its broadest sense underwriting means the entire process of conducting an insurance enterprise; in its narrowest, only determination of whether a risk will be accepted or rejected by an insurer. Of late years, the term "underwriter" has to some extent supplanted "agent."

"Underwriting," in this chapter, will be used in the sense usually assigned to it: selection of risks for the insurer and determination in what amounts and on what terms acceptable risks will be insured.

> The production department, through whatever means it may employ for the development of business, arranges for a flood of risks to pour into the underwriting department. Here this stream of business is processed, and the good risks are separated from the bad ones by a selective process. Acceptable risks are properly classified and rated, and constant vigilance is maintained over the insurer's business to make certain that it meets the tests established by management with regard to volume, diversification, quality, and profitableness.
>
> The underwriter is primarily responsible for the underwriting results experienced by his insurer. If he is unintelligent, unskilled, irresponsible, inexperienced, lax, or inefficient, the insurer is likely to sustain a ruinous underwriting loss. In fact, the only thing that could possibly save such an underwriter would be an unprecedented run of good luck that would produce a profitable experience in spite of anything the underwriter might do or fail to do. To be permanently successful an underwriter must possess extraordinary intelligence, skill, responsibility, energy, experience, and efficiency, and even so, under prevailing conditions, he will be fortunate if he produces a slight underwriting profit, such are the obstacles that confront him today in the field of multiple-line insurance.[1]

[1] G. F. Michelbacher, "Multiple-line Insurance," pp. 170–171.

The individual risks accepted by insurers are not, like certain types of machinery, each an exact duplicate of every other. Such exact duplication is not found even within any class of insured for the purpose of rate making. And probably no refinement of rate-making technique can find the rate that exactly measures the expected loss and expense in connection with each person to be insured. Fortunately such precision is not necessary to a satisfactory functioning of the insurance business. But, unless insurance of a particular type of risk is compulsory upon all and is required to be in a monopolistic institution, the inability to make such precise measurement imposes upon the insurer the necessity of taking active measures to see that the insureds accepted in each class are not the worst, nor generally below the average of the class.

It is also necessary, in the interest of equity between classes of insured, to assign each risk as accurately as may be to its proper class. In the long run this is also in the interest of the insurer, for persistent overcharging by assigning to a class carrying too high a rate, although possibly yielding some temporary profit, would, when it became known, injure the insurer's standing.

Even if these requirements are met, serious injury to an insurer is still possible through too great concentration of value exposed to a single chance. For example, fire-insurance companies have sometimes found their losses in the conflagrations that have occurred in large cities too great to be met, and liquidation has been necessary. Hurricanes and tornadoes pose a similar threat to insurers covering windstorm losses.

From the old practice of the marine insurers at Lloyd's coffeehouse signing their names under the amounts assumed under their contracts, the term "underwriter" has come to mean one who is skilled in the estimation of risk and the proper terms of its acceptance by an insurer. The work of meeting the requirements just noted is entrusted by each insurer to underwriters, who collectively constitute the *underwriting department* of the insurer. This chapter describes this work in some detail.

FUNCTIONS OF THE UNDERWRITING DEPARTMENT

The functions of the underwriting department are two:

1 To secure a *safe* distribution of risks
2 To secure a *profitable* distribution of risks

The insurance business is analogous to manufacturing: producing certainty as the finished product from risk as the raw material. In manufacturing, the quality of the finished product depends in large part upon the quality of the raw material. Manufacturing enterprises maintain inspection departments

and sometimes expensive laboratories to test raw materials in order that only a satisfactory and uniform quality may be accepted and used. If it is possible to use different grades, this department classifies the material and assigns it to its proper use. The underwriting department of an insurer has a precisely analogous function.[2]

Adverse Selection

The optimism of human nature is such that the worst risks are most likely to seek insurance. Therefore, the risks that any insurer finds easiest to get and to hold are the poorest in their class. Further, individuals, in the conduct of their affairs, naturally seek the most favorable terms for transferring their risks, as to classification, policy forms, and rates. This same tendency to think first of his immediate interests leads the insured persistently to choose, where option is open to him, the benefit that he regards as most valuable. This tendency is not to the advantage of the insurer and is known as *adverse selection.* The underwriting department must seek to overcome the effect of adverse selection by a careful selection of the better insureds and careful draftmanship of insurance contracts.

Volume of Risk

The insurance business is founded on the law of large numbers. If the necessary conditions for the successful conduct of business are to be realized, the insurer must secure an adequate volume of business to produce dependable average results, and so far as possible it should obtain such a volume in each class. It is the function of the underwriting department to consult with the business-getting department to this end. In times of prosperity, when business is booming and losses few, some underwriters overlook the danger of adverse selection and rely upon volume alone to give a dependable result. The subsequent loss ratios of their companies usually have a corrective effect.

Spread of Risk

Avoidance of excessive amounts at risk on a single hazard is, as has been noted, a further necessity to the safety of any insurer. This involves the determination of the largest net amount the insurer will assume on a single exposure, the *net line* (the amount remaining at the risk of the insurer after

[2] Many of the functions of the underwriter have been taken over by cooperative organizations. See Chapter 33.

any reinsurance[3]), as well as the aggregate amount that will be taken in one group of exposures subject to a single hazard, such as a conflagration in a congested community (fire insurance), a catastrophe in a factory or other exposure covered by workmen's compensation insurance, or the loss of an excursion steamer whose passengers may have been covered by accident insurance.

Favorable Selection

Favorable selection involves not only the avoidance of excessive lines and adverse selection, but the deliberate selection of the best specimens of each class. For example, some life-insurance companies writing only standard risks limit their writings as far as possible to certain forms of policy because the mortality of persons taking these forms is lower than among insured lives generally.

SELECTION METHODS AND SOURCES OF INFORMATION

Selection methods and sources of information differ materially from insurer to insurer and according to the kinds of insurance written. This discussion will highlight the common elements and the most significant differences.

Preliminary Selection

In all cases the preliminary work of selection must be done by agents or other representatives. Their work must rest upon instructions from the head office. Instructions are communicated in part in rate books, manuals, and circulars issued by the head office to all representatives; in part by correspondence between the head office and the individual; and in part by oral instruction through special agents or through addresses by head-office officials at conventions of agents.

The instructions of a well-organized and well-managed insurer are of two forms:

1 Positive, indicating the business to be sought
2 Negative, in the form of instructions as to types of exposure the insurer refuses or prefers not to accept

Positive instructions usually cover:

1 Classes of business to be sought
2 Amount that may be written on any one insured exposure

[3] See pp. 470–472.

Instructions of the negative type are communicated in definite terms, violation of which frequently carries a penalty. For example, life insurers may decline to pay for the medical examination of lives whose applications are submitted contrary to instructions. Since all rules are subject to exception, the procedure in cases where the agent feels that an exception should be made should also be covered. The agent is usually instructed to refer such cases to some supervising officials of the insurer.

From this point, underwriting procedure differs markedly between those classes of insurance where the agent has the authority to bind the insurer and those where the application is first submitted to the head office, which issues the policy.

Sources of Risk Information

In life insurance the prospective insured signs a written application which contains pertinent personal information, including certain statements made to the insurer's medical examiner. These become part of the contract and bind the insured as representations. In health insurance and some other kinds of insurance, signed applications are also often required. Where an application is not taken, some information, whether or not written on a schedule of declarations, is communicated to the insurer's representative by the insured. These representations furnish the first evidence for underwriting purposes, but they are not adequate for thorough protection of the insurer.

Insurers consequently seek further information by examination and investigation on their behalf. This practice is most highly developed in the field of life insurance. Usually the applicant must be examined by a physician on behalf of the insurer, who sends his report of examination direct to the head office of the insurer (or to a branch office) in order to protect him from pressure by agents whose commission depends on acceptance of the risk. Many insurers have undertaken issuance of policies up to specified limits without medical examination. In such cases the statement required from the applicant is more detailed, and more careful inspection is made.

In addition to arranging for the medical examination, the home or branch office, on receipt of the application, refers the case either to its own *inspection department*, if one is maintained, or to an organization whose business is investigation of risks for life insurers. These agencies attempt to ascertain the financial standing of the applicant, his associations and habits, and any facts about him that would tend to show whether he is a satisfactory insured. Such reports are sent direct to the home or branch office and are held confidential.

Since the dishonest person who fails in his first attempt is persistent and

will often apply elsewhere, concealing the facts he believes to be the cause of his prior rejection, it is desirable that insurers be warned of rejections. Life insurers doing business in the United States may be members of the Medical Information Bureau to which rejections are reported, with particulars for identification and a code designation of the cause of rejection. Cards carrying this information are sent from the bureau to all member companies and are carefully filed. This indexed file is searched on receipt of any application at the home office as the first step in the underwriting procedure.

Some insurers request of an inspection company a similar report on all or certain classes of applicants for automobile liability insurance, e.g., young persons, such as college students, and those whose residence or other facts recorded in the declaration raise questions as to improper use of their cars in criminal or other hazardous activities.

Insurers writing other classes of insurance have similar types of information on which to base underwriting action. Another example will probably suffice. Except in the case of isolated farm exposures, a written application is not required for fire insurance. Head offices, and important branch offices or general agencies, are equipped with insurance maps. These maps show the location of all buildings in the area mapped, including outbuildings, such as garages, water towers, or storehouses. The type of construction and use are indicated by distinctive coloring and other markings. A glance at the map tells the experienced underwriter the physical nature of the risk offered. If he has doubts, he may usually obtain from the rating organization covering his territory a copy of the inspection report on the basis of which its rate was fixed. He also has detailed reports on the characteristics of the community that are likely to affect fire risks in it. He can in that way judge the adequacy of water supply, fire-department, and other protective features. Often underwriters have been special agents and are more or less familiar personally with the principal features of the cities and towns in the territory which they are underwriting. If the underwriter needs additional information as to the financial standing of the owner, he may refer to the reports of such agencies as Dun and Bradstreet, or he may call for a special report. Here, as in other lines, insurers keep records of suspicious fires and claims.

In some lines of insurance, such as workmen's compensation and to some extent liability insurance, the expected frequency of loss is such that the insurer may gain some evidence of the quality of the exposure from its own files. The underwriting department of an insurer writing such insurance customarily reviews the record of each insured for a reasonable time before the expiration of the policy and, if it is not considered a desirable insured, notifies the agency of its unwillingness to renew. On insureds carried for long terms, there is often a considerable volume of data on which to base judgment.

A difficult problem in underwriting is that of avoiding actual or potential

fraud—the moral hazard. No sure rule that will be an effective defense against moral hazard has been devised, nor can be. It would be an unwise and unjustifiable attitude for an underwriter to assume moral hazard in every case. But fraud uses so many and such clever disguises that he cannot afford to close his eyes to any suspicious indicia. Experienced underwriters, especially those who have had some work in the adjustment of claims, seem to develop a sixth sense by which they detect such cases.

Mode of Selection

The manner in which underwriting selection is practiced differs according to the kind of insurance, depending primarily on whether the agent has the power to bind the insurer.

When only the head office has this authority, unacceptable applications are rejected, and the agents are notified to refund any premiums accepted. This is the practice in the life-insurance business.

If the risk is not wholly unacceptable but may safely be taken on some other plan or basis than that applied for, a policy on such a plan or basis may be offered. Since such a policy is not in accordance with the insured's order, it is necessary to send with the policy an amendment to the application, to be signed and returned by the insured in order to complete a binding contract.

In the case of policies bound by local agents without knowledge of the underwriters until receipt of a daily report (a copy of the written part of the policy and its endorsements) prepared by the agent, the only alternatives are to accept the risk or cancel. If cancellation is necessary, the agent is usually notified to effect cancellation and is allowed a reasonable time in which to do so in order to protect his personal business interests. Sometimes the contract is not canceled but the insurer indicates its intent not to renew the contract after the present term expires. Cancellation causes so much inconvenience and dissatisfaction to all concerned that it is avoided wherever possible, the underwriting department endeavoring through special agents and notices to agents to prevent issue of the policy in the first instance.

Contracts that must be renewed periodically are reviewed prior to the expiration date. If the insurer learns through claims or otherwise of a serious impairment of the quality of the exposure, it may notify the agent and the insured of its intent not to renew.

Competition

Competitive conditions play no small part in handicapping underwriters in their work of selection. Most persons needing insurance place their orders through brokers or agents, often chosen because of personal friendship or business

connections. Brokers and agents who represent several insurers writing the same kind of insurance may place the insured's exposure with any one of several insurers. A particular insurer may be offered a volume of business of the kind it most desires and at the same time a few risks that it does not want. To retain the good will and patronage of the broker or agent in question, it may have to take the unwelcome business ("accommodation risks"). Representatives trying to avoid undesirable risks have been told in such cases they must take "all or none." The underwriter faced with such conditions must weigh the advantages of the desirable business against the disadvantages of what he wishes to reject, and also give consideration to the value to his company of future business with the broker or agent. But he should not overlook the effect of a weak attitude on their future conduct.

DRAFTING OF CONTRACT FORMS

Careful draftsmanship in the preparation of contract forms greatly assists underwriting work, and underwriters give much time and thought to the drafting of policy forms and endorsements as well as to instructing representatives in their proper use. Carelessly drafted forms and absence of appropriate endorsements may result in exposing the insurer to hazards not a necessary or appropriate part of its business. Among these are:

1 Assumption of risks not provided for in the rate
2 Excessive moral hazard
3 Excessive morale hazard
4 Adverse selection
5 Nuisance claims, i.e., groundless claims often paid to avoid further trouble
6 Small claims involving disproportionate adjustment expenses
7 Underinsurance
8 Complex adjustment problems due to overlapping of policy contracts
9 Overinsurance

The safeguard against the first of these dangers is precise definition of the risk assumed, which often requires specification by exclusion. The risk must be carefully defined with respect to the covered perils, property or sources of liability, persons, types of loss, locations, and times.

Less can be done in drafting forms to safeguard against moral hazard. Making the contract consistent with the concept of indemnity is one approach. The unusual features of the hail-insurance contract described on pp. 294–295 represent another approach.

The resumption clause in business-interruption forms, the reference to failure to harvest in the hail form, and deductible provisions are examples of

efforts to reduce the hazard of poor morale. But such hazard cannot be entirely eliminated.

The nature of the provisions that must be inserted to reduce adverse selection is illustrated by the provisions as to premium payment and cancellation in the riot-and-civil-commotion contract, by the provision in the hail contract that coverage commences 24 hours after signing by applicant and agent, and the requirement that the rain-insurance policy must be applied for a week in advance.

The safeguard against nuisance claims is their discouragement by refusal to settle groundless claims, a remedy that is likely to be efficacious only if generally applied. Uneconomic coverage of small losses may be eliminated by a deductible clause or franchise clause. An average or coinsurance clause is a safeguard against underinsurance.

Safeguards against complex adjustment problems due to overlapping contracts are careful definition of the risk assumed and adoption of mutually exclusive definitions.

Provisions that make the contract a contract of indemnity provide a safeguard against overinsurance.

ASSIGNED RISK PLANS

For reasons of policy, because of governmental pressure, or in observance of statutes, insurers have found it advisable or necessary to insure risks that they would not individually accept. In the workmen's-compensation and automobile-liability fields, a business may not be able legally to operate, or a car owner or driver may not be able to secure registration or an operator's license, without insurance. Even if the withholding of insurance protection does not stop an employer from legally operating his business or the car owner or driver from maintaining or driving a car, the rejected applicants may be unhappy because they want insurance protection for its own sake. Recently the failure of insurers to provide adequate protection in certain urban-core housing areas has attracted considerable public attention. Refusal of insurance may result in popular antagonism to insurers and to demands for governmental insurance.[4]

One method of meeting this situation that has widespread use in workmen's compensation and automobile liability insurance is the *assigned-risk plan*, an organization of insurers receiving applications from "undesirable risks" and distributing them to insurers in proportion to their volume of business in the

[4] Complaints about the availability of automobile insurance were a major factor leading to the federal study of automobile insurance described in the last paragraph of this text.

kind of insurance and in the jurisdiction with which the particular plan is concerned. In the workmen's-compensation plans, many of which are required by law, insureds usually pay higher rates than they would have paid if they had purchased the insurance direct. In the automobile-insurance plans, most of which are voluntary, insureds usually pay a rate that is slightly more than the bureau rate. About 3.2 per cent of the workmen's-compensation premium volume and 3.5 per cent of the automobile-liability-insurance premium volume is written under these plans. Both types of plan, particularly the automobile plans, have developed excessive loss ratios.

The National Council on Compensation Insurance operated some 20 workmen's-compensation assigned-risk plans during policy years 1961 through 1965, inclusive. The ratio of incurred losses and loss-adjustment expenses to earned premiums during that period was 0.82, well above the ratio contemplated in the calculation of rates.

The situation in automobile liability insurance is much worse. Country-wide data compiled by the National Association of Independent Insurers for 1959 through 1965, inclusive, show a loss and loss-adjustment ratio of about 0.94, which is substantially more than the ratio contemplated in the rates. The poorer experience in automobile insurance may well be due to the lack of control over the individual insured and the generally poor experience over the entire automobile business.

In an attempt to forestall similar plans in fire insurance,[5] insurers developed a few years ago urban-area inspection plans and special-surcharge rating plans for property located in the inner cores of many major cities that could not be insured through normal channels. Although the plans varied in details, they generally provided that no property would be refused insurance until it had been inspected, that no inspected property would be rejected without telling the owner what improvements would make it acceptable, and that surcharged rates could be applied to property that would be acceptable on that basis. The 1967 summer riots caused actions of this sort to be accelerated. In 1968 the President's National Advisory Panel on Insurance in Riot-Affected Areas urged extension and improvement of these plans.[6] Whereas the original plans were usually limited to the fire- and extended-coverage perils and to residences, the Panel recommended extension to commercial properties and to vandalism and theft. These extended programs were termed FAIR (Fair Access to Insurance Requirements) plans. The President's Panel also sug-

[5] In 1965 following a serious riot in the Watts area of Los Angeles, California insurers, at the request of that state's insurance department, established a voluntary pool to provide insurance to businessmen in the affected area who could not secure insurance through the normal channels.

[6] "Meeting the Insurance Crisis of our Cities: A Report by the President's National Advisory Panel on Insurance in Riot-Affected Areas," pp. 8–15.

gested state pools of insurers to write insurance on property in satisfactory condition that because of environmental hazards could not be insured, even under the FAIR plans. They noted that the state might have to subsidize the insureds in the pool as one of their contributions to the revitalization of their inner-core areas. Other suggestions by the Panel included the formation of a federal reinsurance corporation, the deferral of taxes on reserves accumulated by insurers to meet catastrophe losses, studies of more economical methods of marketing insurance, and numerous other measures. The Panel Report also documented the shortage of insurance and the high cost of insurance in the inner-core areas.

Under the Federal Urban Property Protection and Reinsurance Act of 1968, each state is required to have in effect a FAIR plan to provide insurance in urban areas if insurers wish to qualify for the riot reinsurance[7] provided under that act on property located in the state. All FAIR plans cover both residential and commercial property but at this writing coverage may be limited to fire- and extended-coverage perils. These FAIR plans are not permitted to deny any applicant insurance merely because of environmental hazards or to make any surcharges solely for this reason. FAIR plan business is distributed among insurers in two ways. One approach is basically an assigned-risk plan with a joint reinsurance association composed of all insurers assuming responsibility for 1) all or part of the insurance on property which has a significant exposure beyond the control of the insured and 2) that portion of the insurance on other property written under the FAIR plan in excess of the normal limit of liability that the insurer writing the policy has agreed to accept. The other approach is a direct underwriting pool.

In order to spread the loss of unusual riot losses among all insureds, insurers have in most states added civil disorder charges to all fire- and extended-coverage rates.

AVOIDING OVERCONCENTRATION OF EXPOSURE TO RISK

Insurers avoid overconcentrating their exposure to risk by establishing line limits and through various types of reinsurance arrangements.

Line Limits

The problem of line limits—that of avoiding excessive exposure to a single hazard—is very complex, involving consideration of the financial position of the insurer and the largest amount of loss which could be met at one time

[7] See pp. 470–472.

without injury, as well as the possibility of several individual risks being involved in the same loss. For example, to an insurer with a surplus of $50,000, a loss of $75,000 at one time would cause an impairment of capital to the extent of $25,000. But if the insurer had a surplus of $500,000 or $5,000,000, the loss would be less serious. In the latter case it would be scarcely noticeable. Such a loss might also occur to an insurer not writing more than $5,000 on a single insured exposure if 15 of its exposures were involved in the same disaster.

In order, then, to protect the insurer, dual limits must be set: one, of the amount to be taken on a single insured exposure, and a second, of the amount to be taken in a region within which a group of individual exposures may be involved in the same event. Both must be set with regard to the capital and surplus of the company.

In modern life insurance, *shock losses* (those which would financially embarrass the insurer) rarely occur. Conflagrations do occur, and fire-insurance underwriters maintain careful conflagration line limits. To this end, cities are subdivided into districts as indicated by natural fire breaks. Maximum limits are fixed and rigidly adhered to for each district, and usually for each block and building within the district. Careful records are kept of the risks taken in such areas to make sure that the limit is not passed.

The nature of workmen's compensation insurance is such that insurers can set no limit to the amount of any one contract, and a catastrophe, such as a boiler explosion or fire, even in a small exposure, may cause large losses. The statutory limit that many states set on the amount that may be exposed on a single insured exposure (usually an arbitrary 10 per cent of capital and surplus) does not apply. In this, and other cases, where the insurer must write, or desires to write, lines of insurance beyond its limits, resort is had to *reinsurance.*

Reinsurance

In all lines of insurance the insurer, to satisfy field representatives or insureds, must often write a larger amount on a single insured exposure, or in a single region, than it can carry safely by itself. It may properly do so by taking out reinsurance payable to itself covering the excess. Reinsuring is a very old practice and has, in recent years, attained a position of a great importance, with appropriate developments in method.

In the early history of insurance, underwriters held rather rigidly to their own line limits, and it was the province of the insured or his brokers to procure a sufficient number of contracts or the signatures of a sufficient number of underwriters (in the case of Lloyd's contracts) to give adequate protection on

the property covered. But even under these conditions an insurer might find a risk accepted which, when added to risks already covered, resulted in a total line exposed to a single peril larger than good judgment dictated. One or more of the risks was then reinsured individually by offering it in whole or in part to other underwriters. If the risk was accepted, a policy was issued in favor of the original insurer. The interest of the first insurer is an insurable interest. In all such cases the obligation of the reinsurer is to the insurer only; the original insured is not in any sense a party to the reinsurance contract.

This practice is still resorted to on occasion, but it is slow, cumbersome, and expensive. It may result in loss if the event insured against occurs before the reinsurance contract is obtained. The practice has, therefore, grown up of providing reinsurance facilities in advance of need by contracts or *treaties*. Such contracts are written by insurers that also do business with individual insureds, often on a reciprocal basis but sometimes through a reinsurance department that aggressively seeks such business. Many insurers belong to reinsurance pools which permit them to exchange reinsurance. However, a large number of insurers have been formed to write reinsurance exclusively. There are now several such American reinsurers, as well as European reinsurers that maintain branches in the United States. Much reinsurance is placed direct with reinsurers in other countries, especially in London.

Various forms of treaty have been, and still are, in use. They can be classified in two ways: (1) according to whether the reinsurer is bound to accept the reinsurance offered under the treaty (facultative or automatic) and (2) according to the way in which the losses are to be distributed between the two parties involved (excess, quota-share, or catastrophe).

The *facultative treaty* is the first departure from seeking separate reinsurance of individual risks. Under it the reinsurer and reinsured make a contract under which risks may be submitted. The insurer is not bound to submit for reinsurance any particular part of its business, nor is the reinsurer bound to accept, though sometimes it is provided that the reinsurer is bound from the time of submission unless it rejects. If the reinsurer accepts the business, the terms of the contracts are those embodied in the treaty.

The *automatic treaty* differs from the facultative in that the insurer binds itself to cede some portion of the business it writes directly according to terms set up in the treaty, and the reinsurer binds itself in turn to accept such *cessions*. The treaty provides for periodic accounting and for settlement of accounts.

An excess-reinsurance arrangement binds the reinsurer to pay losses incurred by one insured in excess of some specified amount up to some predetermined maximum. This type of reinsurance, therefore, protects the insurer against shock losses to a single insured.

Quota-share reinsurance binds the reinsurer to pay a stated fraction of

every loss, regardless of its amount. This form of reinsurance is less used as an underwriting tool than as a means of so arranging the financial affairs of a new and small insurer that its growth and development do not involve too much strain on its financial resources. It permits larger acceptances than would otherwise be possible. It is most frequently used by the smaller companies of a group under common management to satisfy agents and increase the spread of business of the parent company. Other things being equal, an insurer using this arrangement would be expected to pay more in reinsurance premiums than one relying upon excess reinsurance. However, an insurer adopting, say, a 50-50 quota-share program would normally pay for this reinsurance less than half of the premiums received from its insured because the reinsurer will allow a commission to the original insurer covering its share of acquisition and other costs and taxes.

A further development of this practice is found in an arrangement among the insurer members of a fleet under common management, usually also having a large element of common ownership. A contract is entered into among the several insurers under which 100 per cent of their direct writings are automatically and immediately ceded to the largest insurer of the fleet. That company, after procuring such outside reinsurance on individual risks as its underwriters deem necessary, apportions the remainder among the fleet members in fixed ratios. For example, it might retain 50 per cent, a second insurer might receive 30 per cent, and two others 10 per cent each. In some cases the smaller insurers are in effect only agencies, the parent insurer taking over their entire business and giving them an appropriate share of its underwriting profits, if any.

Catastrophe reinsurance is designed to protect the insurer if its aggregate losses (all insured losses combined less reinsurance recoveries of other sorts) caused by a single event such as a tornado or an explosion exceed a specified amount, such as $500,000. The reinsurer may then be liable up to an amount provided in the treaty, e.g., $1,000,000. Under a treaty with these limits the original insurer, after deducting other reinsurance recoveries, would be reimbursed, if the loss exceeded $500,000, for the full excess, unless the total exceeded $1,500,000. This reinsurance would permit the insurer to recover even if the loss to any particular insured were small if many insureds were involved in the same event. The limits chosen for such reinsurance must be set by the underwriters for the original insurer with due regard to its business and resources.

Whatever the arrangement for reinsurance may be, the aim is the same: to permit an insurer to write a maximum amount of insurance, and at the same time to protect it from loss due to concentration of amounts of insurance exposed to single occurrences.

QUESTIONS

1. Does a highly selective underwriting policy always result in a safe distribution of insureds?
2. What relationship would you expect to find (*a*) between the ratios of losses to value of insured property and of all property of the same class? (*b*) Between the mortality per 1,000 lives of persons insured under life-insurance contracts and of the general population?
3. In placing fire insurance on a risk, it is frequently necessary to effect contracts with several insurers. Why?
4. Why are underwriters interested in the financial status of an applicant for life insurance? Or a prospective insured under a fire-insurance contract?
5. What resources do underwriters have, aside from statements of the insured and physical inspections, as guides to underwriting decisions?
6. How does the binding authority of the agent affect the selection process?
7. Why is the drafting of insurance contracts commonly entrusted to the underwriting department?
8. Is the assigned-risk plan an adequate solution to the handling of sub-standard applicants?
9. To what extent, if any, would an insured have reason to consider the reinsurance arrangements of an insurer?
10. What is the relationship between an insured and a reinsurer of the original insurer?

31
ADJUSTMENT OF LOSSES

Insurance contracts are principally concerned with defining the obligation of the insurer to pay losses and the manner in which they will be paid. They also impose certain obligations on the insured as conditions of the insurer's promise to perform its obligations. In the usual case, the insured notifies the insurer of an accident or loss, the insurer negotiates a settlement of any claim with the insured or a third party, and the claimant signs an agreement that his claim has been satisfied. The process of settlement is an *adjustment*, and the person representing the insurer is an *adjuster*. The insured may be, but usually is not, also represented by an adjuster. This chapter describes some features of the adjustment process that are fundamental to all fields of insurance as well as those that are peculiar to particular fields.

SOME FUNDAMENTAL FEATURES

Types of Adjuster

The adjustment function may be, and often is, performed by persons whose principal vocation is not that of adjuster, but who, because of situation or qualification, come to be employed in that capacity. Insurance agents frequently adjust small or remote losses in their territories; those who have achieved an outstanding record with their principals may have considerable authority to make adjustments. Brokers regularly represent their insureds in notifying insurers of accidents or losses and in making settlements, regarding this work as part of the service offered to their clients. Lawyers who do not specialize in adjustments are often employed by insurers or insureds.

Full-time adjusters—men (or women) who adjust losses as an occupation or profession—occupy varying relationships to insurers and insureds and are of widely varying competence. Most such adjusters are employees of insurers, called *staff adjusters*, ranging from the senior official who has charge of

adjustments for his company to the junior "leg man" who deals with small losses. Many losses are handled by *adjustment bureaus*—organizations operated by groups of insurers to which losses are assigned by members of the group.[1] *Independent adjusters* set up their own offices and offer their services to insurers on a fee basis. They are often employed where special talents are required or where the work load is beyond the capacity of the insurer's regular adjusters. *Public adjusters* serve insureds in dealing with insurers.[2]

The aristocrat of the adjusting profession is the *average adjuster*, a specialist in marine-insurance adjustments. The conduct of a general-average adjustment may call for as high a degree of knowledge and ability as the most intricate court cases.[3]

Purpose of Adjustment

The purpose of the adjustment should be to do for the insured, or a third-party beneficiary, exactly what the insurance contract has promised—no more and no less.[4] But this is a statement of an ideal. Claimants and adjusters are human beings, varying in attitude, method, and capability. Too often the insured aims to get all that he can and exaggerates his claim, whether from cupidity or a conviction that this is the only safe way to deal with the insurer's adjuster. And the insurer's representative may feel that he should give as little as possible and take a trading rather than a judicial attitude.

Happily, adjustments in general are reasonably amicable and fair, though honest differences of opinions are inherent in the situation. At no point in the operation of the insurance mechanism is there greater opportunity for convincing the public that insurers are eager to do, and are doing, a good job in the public interest. But this opportunity should not mean buying public favor by unduly liberal adjustments. Such a policy encourages false or exaggerated claims and is reflected in inflated premium rates.

Procedure

The process of adjustment varies considerably between kinds of insurance, but certain steps must be taken in practically all, if not all, cases. The first step is to ascertain whether there is a contract of insurance in force under

[1] See p. 508.

[2] Unless otherwise specified, further references to the adjuster will apply to the representative of the insurer.

[3] See pp. 192–195.

[4] This is not to say that the contract should be interpreted legalistically; it is the spirit of the contract that should, and generally does, govern.

which the insurer may be liable for protection or service. If the contract itself is in order, has the insured committed any breach of it? If there is such a contract, does it cover the property, operation, or situation out of which loss has arisen, and does it cover the particular claim? To answer this question, the adjuster must consider both the nature of the claim and the person who makes the claim; it may be clear that a loss is payable, but it may not be payable to the claimant.

An accident or claim may be of such a nature that immediate action is desirable to ascertain facts or to hold the loss to a minimum. If there is any doubt of coverage under the contract, the adjuster may proceed under a *nonwaiver* agreement to the effect that any investigation or ascertainment of value or loss shall not be a waiver of the rights of insurer or insured nor an admission of liability by the insurer. Otherwise the activity of the adjuster, especially if he puts the insured to any trouble or expense, might be construed as a waiver of the insurer's rights or an admission of its liability.[5]

Further procedure will depend on the type of claim and the type of insurance, though in all cases the final result should be the same—adjustment of the claim fairly and to the satisfaction of the insured, while protecting the insurer against undue loss. In adjusting claims for loss of the insured's property the adjuster must ascertain the sound value (the value immediately before the loss) of the property insured and the amount of the loss caused by a peril insured against. He must determine his principal's share in the loss if there is other insurance, whether a coinsurance or average clause limits the insurer's liability, whether the loss is payable in whole or in part to third parties, such as a mortgagee or assignee, whether any third party other than an insurer might be liable to the insured for the loss; and he must gather evidence to support any claim of such liability.

The procedural details are so diverse and so numerous that only specialists in particular types of loss have thorough command of them.[6]

Attitude of Claimants

In most classes of insurance the difficulty of loss adjustment is often enhanced by an adverse attitude on the part of claimants. Few insureds read their contracts in advance of an occurrence resulting in loss of the type that they assume the contract covers. Consequently, many invalid claims are presented in entirely good faith. Even when the claimant, after conference with

[5] The protection afforded the insurer by a nonwaiver agreement is more limited than its terms might suggest. See Edwin W. Patterson, "Essentials of Insurance Law," pp. 533–536.

[6] See, for example, Prentiss B. Reed, "Adjustment of Property Losses," chaps. 2 and 3.

adjusters, admits that the claim is not justified, he often feels aggrieved at the insurer, either for putting into the contract what now seem to him improper restrictive clauses, or at the agent or broker who, he believes, misrepresented the contract. For, whatever the fact as to the fairness of the restrictive clause or the fullness of warning by the agent or broker, the claimant whose claim is not recognized often is an emotional rather than a reasonable being. Liberal recognition of such claims is, of course, improper, because the insurer that recognizes them in large numbers jeopardizes its solvency, on which the protection of other insureds rests; and, even if it does not injure itself permanently, such recognition tends to raise the cost to the public, because it is only from premiums assisted slightly by investment earnings that losses and expenses can be paid. Refusal to recognize such claims gives the insurer a bad name for hypertechnicality. Adjusters must, therefore, weigh carefully the loss involved in recognizing these claims against the loss involved in the creation of adverse criticism.

Not only is the attitude of the claimant often adverse in this respect, but it is also adverse in respect to valuation of property. He feels the purpose and intent of insurance is, so far as possible, to put him back in the position in which he was just previous to his loss. It is rarely possible fully to realize this purpose. Consider, for example, a loss by fire in which household furnishings have been in part destroyed and in part badly damaged. Assume that the furniture was well made, is about 5 years old, and has been well cared for. To its owner it has many years of useful life. He has become so attached to some pieces that there is an additional sentimental value, but he will usually waive that as not replaceable. Repairs, if well done, he accepts with fair grace. The repaired pieces look fairly well. But those pieces that are destroyed! The amount payable under the policy is their replacement cost new, less depreciation. True, he could not have sold them for what they originally cost. But he had no desire to sell. He needs the same kind of thing. He can get them for the amount payable for his loss only by buying secondhand stuff. He does not want someone else's castoffs. He has to suffer all the inconvenience of renting another apartment until his own is restored. He has to find new things. It is very difficult, indeed, for him to feel that he has received what he thought he paid for, when he is paid a cash sum equal to the value of his goods and must himself attend to replacement. He, or if not he, surely his wife, would strongly resent the barest hint of a desire to replace with secondhand goods. Let the reader try to visualize himself in the position of the claimant and then, in the role of adjuster, try to satisfy himself. The illustration has been taken from the fire-insurance field. The principle applies broadly to many others.

These difficulties have been encountered since the beginning of the practice of insurance. Since full payment is the expected thing, the insured takes full

payment of a fair claim as a matter of course. If inquiry is made, he will commend the insurer but he makes no special effort to do so. But the claimant whose claim has been rejected or scaled down, unless he has been caught in downright fraud, is not loath to speak of it. He feels aggrieved and seeks the opportunity to impress the unfairness of the adjustment on all who will listen. The result is a widespread belief that insurers do not pay, and do not intend to pay, the claimant what he asks, whether or not it is a fair measure of his loss; that it is the province of the adjuster to scale down claims; and that his compensation is based on the reduction he makes regardless of how he makes it. The natural defensive action is to pad the claim for the amount it is believed the adjuster will try to cut it. Many an honest insured has made an exaggerated claim in the belief that it was necessary in order to get his just indemnity. It must be said with regret that there have been, and are, insurance organizations, in dealing with which exaggeration of claims is really a necessary measure. But it is not necessary when one is dealing with insurers of the highest standards, and it is the authors' conviction, after many years of close contact with various branches of insurance, that it is not necessary with most of the well-established insurers.

In the above, downright fraud has not been considered. Any experienced claim adjuster can furnish abundant evidence of efforts of those who live by their wits to perpetrate fraud upon insurers. The protection of the public from arson and like crime, as well as the defense of the treasury of the insurer, require that the claims of this gentry be rejected. But they are so skillful that they often collect; and the fear of the adjuster that the claimant who has obviously been overzealous in his own interest may be of this type does not make any easier the problem of meeting the adverse attitude of the honest claimant.

Not all cases of fraud are presented by habitual knaves, however, nor do many of them cause the same public condemnation and contempt as do most petty thievery and roguery. There is, in the United States at least, a widely shared view that insurance companies and other public-service corporations are "fair game." In most circles it would be deemed clever to have secured payment of a claim against an insurer for a few dollars, or a few hundred dollars, more than was justly due.

But, just as insurers and their adjusters in general take a reasonable attitude toward claim settlements, so do insureds. Were it not so, the adjuster's occupations would be too nerve-racking to follow.

Presettlement Payments to Liability-insurance Claimants

Until recently liability insurers never paid any victim of their insured's negligence any money until they were able to effect a settlement and obtain a complete release of liability or the payment had been ordered by a court or jury.

In the meantime the claimants were often unable to receive adequate medical care and had their lives disrupted because of financial difficulties. The insurers' public image was tarnished in the process. Recently many insurers have made advance payments to claimants in those cases where their responsibility for the accident is clear with the understanding that the final settlement will be reduced by the amount of these advance payments. These pre-settlement payments are part of the growing interest in rehabilitating injured persons and have been used for many purposes other than paying medical expenses and replacing lost income; e.g., for retraining and relocation.

Nuisance Claims

Often presented to the adjuster is the problem of whether to go to the trouble and expense of resisting a small claim that he believes not to have merit, taking the chance that it may develop into a large loss, or to make an adjustment, either in full or for a reduced amount. Such claims are *nuisance claims,* and may be settled for their *nuisance value.* Considering each claim by itself, it is often less expensive to pay it and close it out. It may be questioned, however, whether a policy of paying nuisance values does not encourage such claims and perhaps affect adversely the attitude of claimants making larger claims. It is arguable that, in the interest both of itself and of its insureds, an insurer should reject all such claims and should defend suits brought to enforce them.

Attitude of Agents and Brokers

Among the problems that adjusters must face is that of the agent or broker, either of whom is keen to satisfy an insured claimant. He may be the honest middleman, clearing the way to a proper adjustment through his relationship to both parties to the insurance contract and by application of his understanding of both insurance and his client's situation. But he may act in one-sided fashion to get an adjustment that will please his client—and if he controls a considerable volume of profitable business, he may bring considerable pressure to bear on the insurer.

Salvage and Subrogation

Salvage and subrogation are means to the same end—reduction of the insurer's loss.

Salvage. Perhaps the nature and range of salvage activities can best be explained by a series of examples, as follows:

1 Covering damaged or threatened personal property with tarpaulins to prevent water or exposure damage after a fire
2 Temporary patching of a roof in which holes have been made by fire or by fire fighters
3 Raising the cargo of a sunken ship
4 Raising and repairing the ship itself[7]
5 Cleaning and relabeling canned goods that have suffered no internal damage
6 Drying stocks of clothing damaged only, or principally, by water
7 Sorting damaged goods and selling them at auction or by private negotiation
8 Arranging for immediate sale of perishable products
9 Reconditioning property in the expectation of realizing a greater net return than by selling it in its original damaged condition
10 Taking over and completing a contract in lieu of paying the penalty under a surety bond
11 Persuading relatives or friends of a bonded embezzler to make good, in whole or in part, the loss paid by his surety

Examples might be multiplied—the adjuster must be alive to the possibilities of salvage and, either himself or through specialists in such work, make the most of it.[8]

Subrogation. The principle of subrogation has been explained elsewhere; cases in which it is applicable may be illustrated by examples:

1 A tenant of a building negligently causes fire damage to the building, the amount of which is collected by the owner from his insurer.
2 An insurer pays workmen's-compensation benefits to the driver of a truck who was injured in a collision with another truck, the driver of which negligently caused the collision.
3 A shipper collects from his insurer the value of goods lost while in the hands of a railroad for which, under its bill of lading, the railroad is liable to the shipper.
4 A shipowner is indemnified by his insurer for the loss of his ship caused by collision with another ship in which the latter was at fault.

[7] For an absorbing account of marine salvage, see David Masters, "Epics of Salvage."
[8] See also, Reed, *op. cit., passim.*

5 An employer is indemnified by a surety company for loss due to embezzlement, the proceeds of which were used to buy, for a "friend," expensive furnishings for an apartment and other merchandise still having market value.

Other cases where the insurer would take over and realize on the right of the insured to damages or compensation from third parties would follow the same general pattern.

Other Insurance

It is part of the adjuster's duty to determine to what extent a loss is covered by contracts of insurance with more than one insurer and to calculate the liability of his principal in the light of the liability of others. If an adjustment has been turned over to a committee of adjusters or is being handled by a representative of several insurers, the respective liabilities of the various insurers must be calculated by the responsible adjusters or adjuster. Sometimes it is not clear from the "other insurance" provisions in the contracts how this liability should be apportioned.

Often, in case of disagreement on this distribution of responsibility among insurers, the dispute is settled by arbitration, a skilled adjuster or an organization committee serving as arbitrator. If it is clear that the insured's loss is covered, it may be paid in advance of determining the shares of the insurers. The principal automobile insurers have entered into an agreement for arbitration of all disputed automobile-physical-damage subrogation claims. Another arbitration program handles disputes arising out of codefendant situations or overlapping concurrent coverage under liability contracts. Most property insurers have accepted the most recent (1963) revision of a statement of *Guiding Principles* for the settlement of losses involving overlapping coverage where the covered persons, property, or losses are not the same. Two of these principles will illustrate their application. First, insurance covering a specifically described article or object at a designated location is primary to any other insurance. For example, a glass-insurance contract covering windstorm loss to a specific plate of glass would be primary to a fire-and-extended-coverage contract on the building containing the plate of glass. Second, insurance secured by a custodian covering property belonging to others would be primary to any other insurance.

Subrogation Receipt, Loan Receipt, or Trust Agreement

When the adjuster has developed evidence indicating that the loss may be recoverable from a tort-feasor, he should recommend to the insurer

that at the time of making payment it take from the insured a subrogation receipt.

When the evidence justifies him in believing that a third party, such as a carrier or other bailee or a lessee, is responsible for the loss because of law, trade custom, or contract, or that the loss may be collectible out of other insurance, he should recommend to the insurer that, if it wishes to pay the insured without waiting for a determination of the liability of the third party or of the other insurance, it do so by advancing the amount under the protection of a trust, or loan receipt.[9]

The subrogation receipt is an acknowledgment by the insured of payment of the loss and an assignment of all rights of collection of the amount of the loss from other parties, with authorization to the insurer to settle with such other parties in the name of the insured.

The loan receipt and trust agreement are the same in purpose but different in form. They are agreements by the insured to take steps to collect the loss from responsible third parties, at the expense, and under the control, of the insurer. In practice, the insurer conducts the proceedings in the name of the insured. The purpose of these agreements is to forestall any contention by a third party that it is not liable because the insured has already been indemnified, and also to avoid any prejudice that a jury might have against an insurer claimant.

Disasters

Occasionally disaster strikes a single locality or a wide area, calling for concentration of adjusting effort and speedy mobilization of adjusting resources. One primary cause may result in a variety of insurance losses as in the Texas City disaster of 1947, where the primary cause was explosion, resulting in property loss, both immediately by explosion and later by fire, workmen's-compensation losses, life-insurance losses, and questions of liability under the law of negligence. Other disasters were caused by the Eastern-seaboard hurricanes of 1938 and later years and the earlier conflagrations in Chicago, Boston, and San Francisco, to mention only a few of many. The number of persons or properties involved in loss and the area covered are more significant in creating pressure on adjusting forces than is the aggregate amount of loss. Special equipment and definite plans for meeting disaster conditions have been developed and applied with results satisfactory alike to insurers and insureds.

[9] Reed, *op. cit.*, p. 92.

Reserve Estimates

The adjuster is responsible, in the first instance, for estimating the probable amount of any loss in course of adjustment, the liability for which is not determined by formula. His is the most intimate knowledge of the loss, and his experience the closest. But his estimates may be revised in the home office by officials having a wider perspective. While estimates of individual losses may be far wide of the mark, inaccuracies tend to offset each other, and aggregate estimates are often amazingly accurate.

Repair or Replacement

Insurance contracts covering loss of tangible property usually give the insurer the right to repair damaged property or to replace property that is actually or constructively a total loss. Exercise of the option to repair is a last resort, since the insurer is not in the business of repairing, since it will frequently find itself forced to repair with new materials, and since it is open to a claim that the repair is unsatisfactory. Replacement is practical where the property involved is of standard material and design, particularly in those cases where the loss would be paid in accordance with the retail price of the property, while the insurer can purchase a replacement at the wholesale price. Other replacements, such as that of a used car with another used car, often do not satisfy the insured.

Appraisal

Many forms of contract provide for an appraisal of the loss if the insurer and insured cannot agree on the amount of loss.[10] Since the insured must stand half the cost of appraisal, this is a weapon in the hands of an unscrupulous adjuster to force a small discount on a claim. No respectable insurer will tolerate such a practice. Unnecessary appraisals are to be avoided as needless expense. But where the nature of the loss is such that otherwise the parties cannot both be convinced that a fair estimate of the amount of loss has been reached, there should be no hesitancy in resorting to appraisal. Neither party should appoint as appraiser an advocate of his interest, but each should seek a person technically qualified and disinterested, who will take a professional pride in arriving at a fair estimate of the amount of the loss.[11]

[10] See pp. 152–153.

[11] For comments on the use of appraisal, see Reed, *op. cit.*, pp. 237–240, 376–378, *et passim.*

THE ADJUSTMENT PROCESS IN VARIOUS FIELDS

Life Insurance

Settlement of life-insurance claims is simpler than adjustments in any other field of insurance. They are frequently paid within 24 hours of receipt of proof of death. Disappearance cases, which rarely occur, call for investigation. Occasionally, it may be uncertain who is the rightful claimant. This is a legal question, and the legal department of the company will take charge. If the case is uncertain, the proceeds of the policy may be paid into court under an interpleader action, leaving it to the court to decide which of two or more claimants is the rightful beneficiary.

There have been cases of fraud, usually of misrepresentation by an applicant of habits in regard to liquor, of physical defects, or of illness, but under the incontestable clause claims in these cases cannot be contested after the time limit provided by that clause has expired. As the time limit cannot exceed 2 years, these cases are also rare.

The introduction of increased benefits for accidental death has complicated the work of the claim department. During the depression of the 1930's the companies were confronted with many claims under the double-indemnity clause where the insured died from carbon monoxide poisoning. He was found in his garage with the doors closed on a cold morning and the engine of his car still running. Perhaps his business affairs were in bad shape. Was it accident or was it an effort to provide for his family by death what he could not provide in life? Even though the period during which suicide is a defense against a claim for the face of the policy has passed, the beneficiary is not entitled to the doubled benefit unless death was caused by accidental means. Did or did not the policyholder know the danger of warming up the engine in the closed garage? Did the door blow shut? The claim department must decide in such a case whether the evidence of suicidal intent is strong enough to justify refusal of the larger sum and fighting the case in the courts, if necessary, or whether it is better to forget suspicious circumstances and to pay promptly. If such a case is taken to court, the legal presumption is always that the cause of death was accidental.[12] In the same class is the case of falling from a window.

The problem of life-insurance settlements is considerably simplified by the fact that the life-insurance contract is not a contract of indemnity, and therefore no determination of the loss suffered by the insured or the payee is neces-

[12] Death due to inhalation of gas is now commonly excluded from the coverage of the double-indemnity clause.

sary. The amount payable is clearly specified; the only questions are when and to whom.

Health Insurance

In health insurance the personal factor is of major importance. Given a well-balanced insured, interested only in collecting what the contract promises, and an adjuster similarly well balanced and interested in carrying out the contract, little difficulty is experienced. But since so much depends on the attitude of insured and adjuster, and since the evidence is largely intangible, satisfactory adjustment is often extremely difficult. An insured may believe himself to be disabled when physically he is in normal condition, or he may consciously create or feign disability in order to collect benefits. When he can receive care—hospital, medical, surgical, or nursing—at the expense of the insurer, he may feel a need for it that would otherwise be absent. Or again, he may have created the need by self-maiming or by malingering. The adjuster may be too much interested in making a record for low losses or represent an insurer whose loss-payment practices are less than ethical. Many of the classical instances of fraud, malingering, and self-maiming are drawn from the experience of insurers writing health insurance. The most flagrant cases of defrauding of claimants by badly managed claim departments have also been found in this field. Perhaps the two facts are not unrelated.

The definitions, limitations, and exclusions of health-insurance contracts, particularly those of the limited low-premium variety, coupled with the notorious lack of interest of insureds in the terms of their contracts *previous* to a loss, give rise to difficulties. The insured often believes that the coverage of the contract is more extensive than it actually is. The disability clause used in life-insurance contracts, originally intended to cover only *permanent total* disability, presented what in many cases was an unanswerable question: would the total disability be permanent? The present provision that total disability of a specified duration will be presumed to be permanent has done away with considerable controversy, though determination of total disability is not always easy.

Sometimes the adjuster must question the charges of doctors, nurses, hospitals, and other vendors of medical services who increase their charges or render unnecessary services when insurance is involved. Fortunately, however, a relatively small number of persons create such a problem.

With advances in cooperation among insurers, regulation, and greater realization of the role of health insurance, conditions have vastly improved. While adjustment is still not a simple matter, it now proceeds to a greater extent on the assumption that this insurance is written to benefit *both* insurer and insured.

Property Insurance Other Than Marine

Property insurance (loss of property and consequential losses) presents problems of coverage because of its traditional practice of insuring against loss by particular causes, rather than against loss as such. But these problems are becoming less as multiple-peril and all-risks contracts are more generally used. The principal problems are those of sound value (value before the loss) and amount of loss. These problems vary from the simple valuation of a piece of furniture completely destroyed by fire and bought the day before the fire from a reputable firm to the determination of what profit an establishment partially shut down because of damage to its power plant would have made if the damage had not occurred. While the adjuster can usually handle the simpler losses himself, he may have to consult engineers, accountants, or salvors in the more complicated cases.

Outright fraud, including arson, is unusual in these fields, but it is important to combat it when it does occur.[13] Exaggeration of claims, honest or tinged with fraud, is more common. Controversies concerning coverage are sometimes acrimonious,[14] but the general tendency is toward liberality in interpretation of the contracts.

Loss by theft and by damage to automobiles are the exceptions to the rule. Fraud, exaggeration of values, sincere or not, and honest claims of theft when the only ascertainable fact is disappearance are common. Much of the property insured against theft represents concentrated value, for example, jewelry and furs, and concealment or intentional "loss" is tempting. Simulation of automobile theft is not too hard to arrange, and the owner of an automobile is prone to believe that its condition is superior to that of the average whose value appears in the used-car books. Owners of cars damaged in collisions like to collect enough to leave an excess over repair cost equal to the amount of the deductible; they are sometimes assisted by complaisant repair men, but much is being done to train adjusters in making more accurate estimates and to check those of repairers.

Marine Insurance

Marine-insurance adjusting is highly specialized and difficult work. The average adjuster must operate under a wide variety of contract provisions, often drawn to suit individual cases; he deals with complicated interests and losses,

[13] See Abraham Kaplan and Samuel A. Berger, "The Dachis Case," and Harold Dearden, "The Fire Raisers."

[14] See Abraham Kaplan and George I. Gross, "Report on the Lily-Tulip Cup Case."

particularly in settling general-average losses; and losses occur throughout the world, often at sea and sometimes leaving no witnesses. There is even specialization within the field. The general-average adjuster is a specialist whose adjustments are independent of marine insurance but determine amounts for which marine insurers may be liable.

While personalities enter into marine as into all loss adjusting, the marine adjuster deals primarily with business losses which are supported by records. He must have a broad knowledge of marine law, contract interpretation, rules, and customs. Salvage operations are of great importance in reducing net losses to insurers.

Liability Insurance

The liability adjuster has a many-faceted task. He must investigate some accidents, even though there seems to be little or no probability of a claim, since a claim may be made; investigate claims, even when he is convinced that they have no merit; deal with claimants who have no contractual relationship with the insurer and consequently no interest in maintaining a good record with it; deal with claimants whose claims are inspired only by the theory that they can probably collect something, regardless of merit; uncover simulated injuries and other fraud; and corral witnesses who are often unwilling and usually uncertain or inaccurate. These are the troublesome items. He also has cases where it is clear that liability exists, the claimant is fair and cooperative, and adjustment is a straightforward and reasonably simple matter.

In dealing with claimants, the adjuster must always have in mind the possibility of legal proceedings in the form of a suit for damages. He should secure whatever evidence may be needed by the legal department in defending or compromising such a suit. Even if he makes a settlement and secures a general release, an action may be brought in an attempt to show that the settlement and release were improperly obtained. He should not think solely in terms of the soundness of the defendant's case. He must weigh the cleverness of plaintiff's attorneys; the insured's desire to avoid trouble or to favor a friend; the attitude of juries, their sympathy for individuals and their feeling that insurers are fair game; the gradual liberalization of the common law. These considerations may make it wise to settle a claim or pay a larger amount than seems otherwise justified rather than risk litigation. On the other hand, there is always danger of encouraging claimants to make claims of little or no merit.[15]

[15] For a detailed discussion of the principles of investigating, evaluating, and settling liability claims, see James H. Donaldson, "Casualty Claims Practice," chaps. 17–22.

While the insurer is under no contractual obligation to pay a liability claim until the claimant has secured a judgment, an insurer often will pay a reasonable claim where liability is clear, without contest either by the adjuster or in the courts. Claimants and insurers sometimes agree to submit claims to arbitration.

The inclusion of medical-payments coverage in liability contracts has added an element of health insurance, since the adjuster's task here is to determine the causal connection between an accident and the services for the cost of which the insurer is liable, as well as the propriety of the charges.

Workmen's Compensation Insurance

The adjuster of workmen's-compensation claims is in a position as different from the liability adjuster as is the workmen's compensation law from liability law. He must determine whether the claim is covered by the compensation law and, if so, arrange for whatever cash payments or medical care is provided by the law. His chief problems are to establish the extent of the claimant's disability, if any, the care needed, and in death cases, the facts of dependency.

Bonds

Claims under bonds call largely for detective and salvage work. The obligee under a bond ordinarily has little difficulty in proving his loss and the liability of the surety—particularly in the many cases where the loss is much greater than the penalty of the bond. Surety companies endeavor to collect salvage from defaulters and others implicated in the loss. This recovery procedure has a wholesome effect.

It is essential to efficient adjustment of loss that insurer and insured have a genuine meeting of minds when the insurance is written, and that their understanding be embodied in clear contract language. A large share of the difficulties that arise in adjustments lend point to the rule that, in arranging insurance, one should always "take the point of view of the loss."

QUESTIONS

1 It has been suggested that insurers should pay only loss-of-property claims for which they are contractually liable, and in liability insurance only claims where the claimant is entitled to damages, even though it might be more expensive in some cases to defend than to pay the claim. Comment.

2 Is it desirable, in the public interest, for insurers to have the right to secure

reimbursement from responsible third parties for indemnity paid to claimants? Comment.

3 Under what circumstances do insurers find it advantageous to repair or replace property rather than pay indemnity? Under what circumstances is it advantageous to insureds?

4 Compare the proper attitudes of an adjuster in settling a liability-insurance claim and in settling a workmen's-compensation claim.

5 Distinguish between staff adjusters, independent adjusters, adjustment bureaus, and public adjusters.

6 Under what circumstances might a nonwaiver agreement be used?

7 How does the insured benefit from the *Guiding Principles?*

8 Why are life-insurance claims usually simple to adjust? What problems do arise in this field?

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INSURER ORGANIZATION

For conducting the affairs of any business enterprise in an orderly and effective manner, a suitable form of organization is necessary, the complexity of which depends on the intricacy of the business. A review of the problems of insurers as outlined in the immediately preceding chapters should indicate that, to be successful in meeting them, a carefully worked out organization is essential to any insurer. Organizations differ greatly according to the type of insurer, the field of its activities, and the type of risk it assumes. The following outline assumes a stock or mutual corporation of substantial size. It will require considerable modification at several points, if the insurer is a reciprocal exchange, a small stock or mutual insurer, or other type. The outline is a composite picture and does not represent any individual insurer or group of insurers.

AUTHORITY, DIRECTORS, OFFICERS

Source of Authority—Stockholders, Insureds

The original source of authority in any business is the proprietor; if it is a corporation, the owners of the corporation. If it is a stock corporation, the owners are the holders of the stock, and their individual rights and powers are measured by the number of shares held. In some of the older stock insurance corporations the insureds were also given a voice in the management of the corporation, but the practice of making provision for such control is now obsolete, and even in the survivors of the earlier type, the provision is meaningless in practice because the insureds almost never exercise their rights. If the corporation is mutual, the owners are the insureds, and their respective rights

are defined by the charter and by-laws. Sometimes a statement of these rights also appears in the policy contract.

The power of the stockholders or insureds is exercised through an annual meeting at which the reports of officers and directors are presented for ratification, and directors or trustees are elected as provided by the charter and by-laws. In practice, such meetings are usually held by proxy, and opposition to the management is rare. The disgruntled mutual insured lets his policy expire and fails to renew, or cancels it and gets out. Strife between stockholders is usually settled by one faction buying the other out. If the officers and directors do not have the confidence of the stockholders or insureds, there is little hope of success for the company.

Directors or Trustees

The real power and responsibility rest upon the directors or trustees. They are usually experienced businessmen in whose judgment and business acumen those who elect them have confidence. They are often bankers or lawyers, and rarely is even a majority made up of experienced insurance men. Although they are charged with responsibility for conduct of the company, they usually exercise their duty by selecting men whom they believe competent to fill the executive offices and whom they hold responsible. Certain of the duties are delegated to committees designated by such names as executive, finance, underwriting, or office. Usually the more important officers are themselves directors. Theoretically, they are annually elected to the board. They have often come up from junior positions and may have been acting as high executive officers for some time before a seat is found for them by reason of death or resignation of some member of the board.

The board meets periodically, receives reports from the officers and committees, and passes the necessary basic resolutions for the conduct of the business. In various ways the executives learn what actions would probably be ratified by the board and what actions would be disapproved. Rarely is there extended debate in directors' meetings.

Officers, Committees, Relations

The officers elected by the directors usually include the *chairman of the board* and the *president.* To these are added, usually by appointment of the board, one or more *vice presidents,* one or more *secretaries,* a *treasurer,*[1] *assistant secretaries,* a *comptroller, assistant comptrollers,* and other junior officers. In

[1] The treasurer's position is often combined with that of vice president or secretary.

the case of a life-insurance company the *actuary* and the *medical director* are sometimes elected by the board. Sometimes the *general counsel* is also an elective officer. Sometimes the work of general counsel is performed by a law firm under a special retainer, in which event one of the senior members of the firm may be a director. Sometimes the general counsel, actuary, or secretary also has the title of vice president.

In the intervals between the meetings of the directors most of their powers are exercised by the *executive committee,* which is chosen by the directors from among their own members. Although occasionally this committee may represent powerful stockholder or insured interests, it is usually composed of the chairman of the board, the president, and several other directors. In a large degree it is the chief executive's cabinet or council, with which broad policies are put in final form for the board's action. There will generally be proportionately much more insurance experience represented on this committee than on the full board.

Determination of the investment policy of the company is usually delegated by the directors to the *finance committee.* A vice president skilled in investment matters is the officer through whom their action usually is carried out.

In addition to these two committees there may be an *underwriting committee* or an *insurance committee* which determines underwriting policies. It will be composed of the chairman (if there is one), the president, and one or more vice presidents. In a life-insurance company, the medical director or actuary, if a member of the board, will probably be on this committee. In any event they are its close advisers. There may also be an *agency* or *production committee* of which the vice president in charge of agency matters will be the chairman, and an *office committee* charged with passing on questions of office management and policy.

The chief executive, who may be either the chairman of the board or the president, is responsible to the directors for the conduct of the company's affairs. The remaining senior officers assist him in general or special fields. The committees of the board are designed to give the assistance of a smaller body with whom details may be discussed more satisfactorily than with the full board.

Junior committees composed of groups of junior officers are sometimes appointed in the larger companies to pass on matters that it would be unwise to delegate to one official, but that are not deemed to be of sufficient importance to take up the time of a senior executive.

DEPARTMENTAL ORGANIZATION

The duties of the vice presidents and other officers depend in part on the insurer's plan of organization, which may divide duties on one of several different bases. The basis of division may be by:

1 Territories
2 Kinds of business written
3 Types of customers to be served
4 Functions to be performed

Sometimes the plan of organization calls for division along all four lines.

Where conditions of competition or supervision require many decisions with regard to operations in particular territories that are independent of matters elsewhere, the territorial basis of division has advantages. Many territorial departments of fire insurers are managed almost as separate companies, with a vice president in charge of each department. Sometimes he is resident in his territory. Sometimes a resident manager is appointed, and the vice president in charge of his territory at the head office, to whom he reports, is the liaison officer between him and the chief executive.

If the insurer does several kinds of business, it is not infrequent to find a vice president in charge of each department. Thus one insurer which does a large life-insurance business, and also a large health and liability business, had for many years four vice presidents, one as a general associate in the president's work, one in charge of the life department, another in charge of the health-and-accident department, and the fourth in charge of the liability department.

One of the more recent developments in departmental organization is the formation of commercial- or business-lines departments as contrasted with personal- or family-lines departments.

The functional plan of organization resembles similar plans in other businesses. Each major department, such as agency or underwriting, is in the charge of the vice president or other senior executive who is responsible to the directors through the chief executive and executive committee for the conduct of his department. Increasingly the traditional functional departments are being realigned. For example, a marketing department may be formed that includes representatives from the production, underwriting, actuarial, and research departments. The ultimate responsibility for coordinating departments lies with the chief executive, but usually there is some form of periodic conference between department heads for consideration of interdepartmental problems. Even when the jurisdiction of the senior executives follows territorial lines or kinds of business, the organization is usually along functional lines within each major division, for the specialized work required in each of the major activities necessarily dictates this kind of organization. Often the functional organization will cut across the territorial.

Whatever plan of organization is adopted otherwise, the financial organization usually serves the insurer as a whole. The chief accounting officer prescribes the form of accounting and manner of reporting and control of finances for all departments. In some cases, a comptroller, charged with auditing and

examining all the financial affairs of the company, is directly responsible to the directors or to the chief executive. Even when, as is sometimes the case, a department is so managed as a separate unit that is charged with such common items of expense as forms and stationery, the general system of accounts and records is prescribed by the head office. Financially the insurer is a unit, all its assets are available for the guarantee of all its contracts, and it is so regarded by the supervising authorities and required to make a consolidated financial report. This could not be done unless the accounts throughout the organization were standardized and unified to that end.

Agency Department

In a small insurer an officer may also have the title of *superintendent of agencies* or *agency superintendent*. As the insurer grows larger, the vice president in charge may yield that title to one or more assistants. If there are more than one, these assistants may be assigned different territories. Each of these territories may again be subdivided into smaller units. The details of organization from this point depend on whether the insurer's organization is predominantly on the general-agency, branch-office, or direct-reporting plan.[2] The function of the agency department corresponds to that of the sales department in a manufacturing enterprise.

The agency department may publish the house organ. In any event it periodically communicates with the fieldmen to keep them interested in the company and alert in their work. In a life insurer, it sets quotas and arranges competitions in production, offering emblems and other prizes, and it arranges regional and general conventions and generally uses its best efforts to keep and enlarge an alert and active set of producing agents. In property and liability insurance, the agent is more often an independent businessman, and calls by fieldmen are used to promote business and assist the agent.

Underwriting Department

Of necessity, because of the special training and information required, the *underwriting departments* are organized by kinds of business and territory and perhaps by type of customer. There is a chief underwriter for each kind of insurance and, except in life insurers where applications are all passed on at the home office, for each major territorial district.[3] He lays out general

[2] See pp. 399–401.

[3] This outline of the underwriting department is that of property and liability insurers. In life insurance, the underwriter is concerned only with initial acceptance of the risk, and then chiefly with applicants about whom there is some question.

plans for passing upon prospective business and himself passes upon the unusual and difficult cases that may be referred to him. He has several assistants of various grades running down to daily-report examiners who inspect each daily report received for conformity to rules and for safety of lines assumed. If the daily report shows no unusual feature, it is passed by the examiner and receives no further attention. Cases raising some question in the mind of the examiner as not in conformity to the insurer's established practice are properly ticketed and referred to his supervisor for further consideration; they may be disposed of by a junior underwriter or, if he deems it desirable, passed on to the chief of the division or department. Before cancellation is ordered, the fieldman covering the territory is usually consulted.

The chief of the underwriting division keeps in touch with the statistical department and secures regular or special reports from time to time on experience by classes and districts revising his line limits and rules in accordance with his interpretation of these data. An important duty of the chief of the department and his leading assistants is service upon committees of rating organizations for the determination of class standards, rules, and rates. In this duty no little responsibility rests upon them for the future of the insurer, as well as for that of the business as a whole. There must be close and cordial cooperation between the underwriting and agency department.

Accounting Department

The *accounting department* has a staff of accountants, bookkeepers, ledger and other clerks. With insurers whose policies are issued by agents, the first steps in accounting for income are recording premium income and keeping track of policies, which are numbered and charged to the agents as sent out. As soon as daily reports are received they come to the accounting department for recording the premiums and for entry in the blank policy registers which were prepared when the forms were sent out. Any break in the order of numbers reported is immediately run down. Brief particulars are entered opposite each number to show the risk. The daily report is then examined by the underwriter and passed on to the files.

When the account current from an agent comes in, it is audited by first checking against these records. Then computation of commissions is verified, vouchers for return premiums and other disbursement credits taken by the agent or examined, and if they are found satisfactory and the expenditure has been authorized, the credit is passed. When the account is found satisfactory, it forms the basis for entries in the agents' ledgers and other subsidiary books from which the general ledger is posted. Details vary so much with the size, kind of business, and other conditions of a company that no accurate general

statement of the work of the accounting department can be made. The nature of the work to be done has been indicated.

A separate section of this department is concerned with investment accounting. Separate accounts of each investment must be kept so that interest may be promptly collected and a change made if it is deemed desirable. Arrangements for the custody of securities themselves are usually made with a bank, though large companies may have their own vaults for this purpose. The bank may take over the entire work of handling securities, collecting dividends and interest, and keeping the insurer informed of such options as conversion and privileged subscriptions. Whether a bank is used will depend both on the policy of the insurer and on the available custodial facilities.

Audit Division

The premium in workmen's compensation insurance is based on the annual payroll of the employer. Premiums in certain other forms of insurance are also based on payroll or on other exposures that are estimated in advance and reported during the term, or after expiration of the policy contract. In these cases provision must be made for auditing the reports of the insured.

Actuarial and Statistical Departments

The *actuary* of a life insurer is both a staff (advisory) and line (administrative) officer. He, with the *medical director*, is the chief adviser on underwriting policies. He consults with the legal department in the preparation of forms and recommends methods for apportioning earnings. He prepares tables of rates and surrender values for policies and consults with the agency department as to appropriate commissions to be paid to agents. Under his direction, statistical studies of experience are made upon which to base the insurer's future plans.

Administratively, his department determines annually the reserve liability under the insurer's contracts, deferred liability under installment arrangements, and any other item subject to valuation on the basis of expected mortality or interest. In the case of policies subject to loans or other conditions, where the nonforfeiture values as printed in the policy do not apply, it makes the necessary calculation. When the basis of dividend apportionment has been approved by the directors, it prepares tables of dividends according to age at entry, plan, and duration, so that the renewal-premium division of the comptroller's department may prepare suitable notices and vouchers.

In insurance other than life, the actuary and his department usually play a

less important part, but that role has increased greatly in recent years as more insurers turn to independent pricing and as statistical theory and data become more important in pricing these kinds of insurance. Furthermore, many insurers are discovering that actuarial talent can be useful in developing applications of computer technology and operations research to insurance.

Although the rise of the actuary in property and liability insurance is a fairly recent development, most insurers have for some time maintained statistical departments which keep records and make reports on classified experience for the guidance of underwriters and actuaries or others charged with the pricing function. If the insurer uses the services of a rating bureau, this department submits experience data in accordance with regular and special calls from the bureau. The computer, however, has vastly increased the status and scope of this department. Indeed, the statistician, or sometimes the systems analyst, has become a key executive involved in almost every function of the insurer.

Secretarial Department

Aside from being the recording officer of the board of directors and its committees, the *secretary* is generally the officer in charge of the records (other than accounting records), files, correspondence, and similar matters of the insurer. In the secretary's department of a life insurer will be found the *division of policy issues* headed by the *recorder,* the *division of policy changes,* the *filing division,* and the *mailing division.* The function of each of these divisions is indicated by its title. Similar duties are imposed on the secretary's department in other types of insurer.

The title "secretary" is also often used for executives in charge of specialized divisions of an insurer's operations; it indicates a rank just below that of a vice president.

Claim or Loss Department

If the insurer is departmentalized by lines of business, there is a separate *claim division* for each important kind of business. These divisions are usually brought together in a central claim department under the supervision of an officer who may or may not have had legal training. Claim adjustments are made in the field by investigators and adjusters working out of the nearest branch or service office, or by independent representatives, but their work must be closely supervised by the head of the claim department.

To this department fall the duties of selecting qualified adjusters and inves-

tigators, training them in their duties, and supervising their work. In health insurance it also selects the medical representatives whose examinations determine the degree of disability. This is the work of the medical director[4] of such an insurer, who also passes upon unusual cases to determine whether the claim is reasonable, the treatment appropriate, and similar questions.

In this department are kept, either at the home office or at suitable branch offices, claim registers from which outstanding unpaid claims and the amount paid on settled claims can be determined. These should be supported by complete claim files in which all papers on each case are preserved. If a case calls for periodic payments in the future, suitable tickler records are necessary to assure that payments go forward as required. There should also be indexes to call cases up periodically for review if the period of payment is not fixed.

No light responsibility rests on this department for estimating the amount of unliquidated claims against the insurer when financial statements are prepared. In property insurance, where the claim is payable in one sum, the amount claimed is entered in the loss register as the claim is registered. Rarely is there basis for change until the claim is adjusted and paid. On the other hand, it is often impossible to determine even approximately the value of a claim for workmen's compensation from the first papers filed, or until much later. It is the custom in many offices to provide for entry of several successive estimated values, and to review the entry each time that new information is received, as well as at regular intervals. The determination of aggregate claim reserves is usually a continuous process delegated to a statistical division within the claim department.

Special Services

In many insurers there are important service departments. For example, the major work of title insurers is the ascertainment that the title record is clear before the policy is issued. To this end the insurers maintain elaborate indexes, or *plants*, of the records of the counties in which they do business. Boiler-and-machinery insurers inspect periodically the properties insured, both for protection of the company and service of the insured. Most large insurers maintain *safety-engineering departments.* Field inspections of plants are made, safety recommendations are presented, and research in safety devices and safe practices is carried on. The statistical department is often called upon for elaborate studies to assist in this work. All such departments are headed by competent engineers, sometimes ranking as officers.

[4] The same title is used for the medical adviser of a life insurer whose work is essentially underwriting. Medical advice is coming to have a larger place in health underwriting.

Supply Department

The *supply department* is usually under the supervision of a competent purchasing agent who may be a junior officer. It is an important division, sometimes maintaining a complete printing plant for the printing of policy forms, advertising literature, and other printed matter.

Personnel Department

The larger insurers, as in other fields, have personnel departments. Their primary duty is seeking and engaging competent persons to staff the insurer, both those who are expected to occupy routine positions and those who it is hoped will rise to the more responsible positions. For the latter type many insurers send representatives to interview and interest students in college and universities. Where the handling of these men is well worked out, they are put through training programs, which may include routing them through the various departments to teach them something of the work of the insurer as a whole and to determine their special aptitudes.

Under this department comes the keeping of payroll and employment records, administration of recreational programs, provision for meals, and similar activities.

The welfare activities that have become so important a part of present-day corporation policy are the responsibility of the personnel department. The devising and administering of various sorts of benefits—wage payments during disability, group insurance of various kinds, workmen's compensation, and benefits under health benefits laws—are assigned to it.

Educational Department

The educational department may be a separate department or a division of the personnel department. It has the duty of training home-office personnel and fieldmen (who often become home-office officials) and often conducts courses for agents and brokers. A special activity is preparing agents to pass state examinations to qualify for license. Smaller insurers do little or no educational work. The larger insurers vary greatly in the importance assigned to this work and in the competence with which it is carried out. In a growing number of insurers, qualified staffs, with adequate equipment and materials do a thorough job.

Publicity Department

The *publicity* or *advertising department* usually prepares and distributes the house organ, if the insurer has one. It prepares and places advertising in

newspapers and periodicals, prepares advertising for the use of agents and advertising directed at securing business from agents and brokers.

This department works in close cooperation with the agency department. In some cases its functions are assigned to a division of that department.

Investment Department

A large insurer may maintain a department devoted to investments, investigating and making arrangements for loans, for purchases of securities, or in the case of life insurers, for direct investment in real property. Final decisions on investment in, or disposal of, securities or other investments are made by the executive (or finance) committee of the directors. A large life insurer will often have a *mortgage-loan* department, which will attend to the necessary services connected with these loans, such as appraisals, insurance, and title records.

Research Department

A few insurers have established research departments whose work varies all the way from studying economic trends and social phenomena to solving immediate practical problems. Market research, product research, and economic research are the three areas most frequently covered and in that order. In recent years, insurers have become more interested in the work of these departments, but the extent to which individual insurers engage in research is almost entirely a function of the research interests of top management.[5]

QUESTIONS

1 Where does the real power and responsibility for the operation of an insurer usually rest?
2 On what bases may the operations of an insurer be departmentalized?
3 Compare the goals of the agency or production department and of the underwriting department.
4 How has the computer changed insurer organization patterns?

[5] J. D. Hammond, "Research and Development Activities of Life Insurers," pp. 43–55.

33
COOPERATIVE ORGANIZATIONS

Perhaps no business is as much addicted to organizations as is insurance;[1] insurers, their employees and representatives, and others interested in insurance all have their special or general associations. The purposes of these organizations, as described in this chapter, are various, but they have a common aim—advancement of the business and of those engaged in it or related to it.

COMPETITION AMONG INSURERS

In the absence of governmental regulation or self-regulation, the natural tendency of insurance is toward the keenest sort of competition. The two principal reasons for this tendency are (1) the fact that insurers' costs are known only after contracts have been written and have run their terms; and (2) the existence of "desirable" and "undesirable" classes of risk, i.e., classes that are expected to be profitable or the reverse. In their efforts to insure the first, and avoid the second, class, insurers may be hopeful rather than practical. New insurers seek the better risks, sometimes to the exclusion of the others; older insurers protect the business already on their books and try to improve their porfolios.

Competition usually centers on one or more of the following elements:

1 Premium rates
2 Contract terms
3 Commissions to agents and brokers
4 Service to insureds

[1] An extensive, though not complete, listing of these organizations—local, state, and national—is to be found in *The Insurance Almanac*. Over one hundred pages of the most recent editions are devoted to them, and membership, purposes, and territory are usually given. References in the present chapter to particular organizations will be only for purposes of illustration.

Although competition has in some respects resulted to the advantage of the public without injury to insurers, as in liberalization of contract terms in some fields of insurance, unrestricted competition along any of the first three lines tends to result in destruction of the weaker competitors and to lower public confidence in insurers and in insurance as an institution. Excessive commissions increase the cost of insurance. In the public interest such competition must be held within reasonable bounds, either by governmental regulation or by voluntary action. The end to be sought is control of competition to preserve only what is beneficial. The sort of competition that results in financial failure or in elimination of competitors by improper methods should be outlawed. Competition in service, contract provisions, or price is to be encouraged, so long as it does not threaten solvency, is not conducted by unfair methods, and is not a mere makeshift to secure immediate advantage rather than long-run improvement.

Competition among life insurers is indirectly limited by the general knowledge among them of what constitutes safe practice and by strict regulation of their financial condition.

The logical ideal is control of competition through cooperation, and efforts in this direction have long been made, even in the face of most serious opposition.

ORGANIZATION FUNCTIONS

Rate Making

In most kinds of insurance, organization for making premium rates is a necessity for many insurers. The principal exceptions are life, health, and marine insurance. Rates are based primarily on statistical data, and their accuracy as measures of relative expected loss and expense, other things being equal, increases with the number of insured exposure units represented by the data. In many cases, only an organization drawing information under a standardized plan from large numbers of insurers can have the basic information necessary to make accurate rates, rates which are adequate and not excessive and which discriminate fairly between insureds. These organizations also enable the insurers using their services tc make more economical and efficient use of scarce actuarial talent.

More debatable is the argument that in order to restrain improper destructive competition the rating organization should have the power to require their members and subscribers to adhere to the organization rates unless they can

support their desire to deviate. One extreme position would prohibit any agreement to adhere to these rates; the other extreme would require all insurers to belong to the same organization and adhere to its rates.

Despite their many virtues, rating organizations do carry with them the danger of too rigid adherence to established methods of rate making and control. Opportunity should always be provided for the development of new methods and for exceptional treatment of the exceptional situation.

In these organizations the source of authority is a governing committee of insurers elected at the annual meeting, whose major duties are selecting the manager, levying assessments on the members for the maintenance of the *bureau* (a term often used to designate such an organization), and determining questions of policy. If membership in a bureau is compulsory and if the bureau is exclusive for its territory, serious grievances are usually referred to the insurance commissioner. Sometimes the governing committee has legislative power, but usually important legislation for the government of the bureau may be passed only by the full membership at annual or special meetings.

The technical problems of classification rules, rate derivation from statistical data, systems for making rates on the basis of physical condition determined by inspection, application of schedule- or experience-rating plans, and other problems of similar nature are usually subject to the control of committees of members on which the insurers are represented by their own technical experts. In one bureau of national scope, regional committees of representatives of insurers with large interests in the state or states covered make the final decision, subject to approval of the insurance commissioner, on rates and rules for the several regions.

Although power in these matters rests with the several committees, the preparation of recommendations to the committees and the carrying out of their decisions rest on the staff of the bureau under the direction of the manager. In the field of workmen's compensation insurance, where different classes of insurers are members of the same organization, an effort is usually made (sometimes it is required by the constitution) to balance the different interests in committee representation. Sometimes apparently minor differences in the phraseology of classifications may gravely affect the business of one or more insurers, or a difference in interpretation of rules may considerably change the cost of insurance to large business enterprises. In such a situation there may be appeal from the decision of the management.

In recent years there has developed a much greater tendency than previously for insurers to operate independently of bureaus, either by following bureau patterns or deviating from them or by setting up their own rates and contracts. Bureaus have responded with a more permissive attitude toward deviations and an "agency filing" procedure. Under this procedure the

bureau files with the state insurance department the rates developed independently by a member or subscriber.

In some kinds of insurance, revision of basic manuals of rules, rates, and classifications is relatively frequent, as new statistical data are secured or the risks covered are changed. For example, the more or less constant amending of workmen's compensation laws, and the development of new processes and machinery, make inevitably the constant revision of classes and rates for workmen's compensation insurance. The situation in automobile insurance is similar, because of such factors as increasing traffic congestion, changes in types of car, new roads, and road rules, changes in driver education, habits, and attitudes, and changing attitudes of judges and juries. However, there are fields, such as fire insurance, where the basic systems of rate making, classifications, and rules change only at relatively long intervals, although in the meantime changes may be made in rates for individual risks, classes, or groups of classes; e.g., towns may be rerated.

In addition to the preparation of basic or class rates, these organizations make rates for individual risks by applying schedule- or experience-rating plans and promulgate such rates to their members. For some kinds of insurance they check the application of the rates by passing upon daily reports. Those found not to be in accordance with the rules are returned for correction of the policy. Those approved are so stamped, from which practice this part of the bureau is known as a *stamping office.*[2]

The bureaus and stamping offices are concerned not only with rates but also with forms and endorsements. The bureaus prescribe the contract forms and the riders and endorsements that may be used, where they are not required by law. Some bureaus print the forms.

Examples of Rate-making Organizations. The principal variations between rate-making organizations are jurisdiction by lines of insurance; territorial jurisdiction; membership, e.g., whether stock insurers, mutual insurers, or all insurers writing a particular line in a particular territory; extent to which they are voluntary or compulsory; and closeness of supervision by state authorities. The following examples are illustrative.

The *Insurance Rating Board* is an organization of many of the leading stock insurers. It was formed in 1967 through the merger of the National Bureau of Casualty Underwriters and the National Automobile Underwriters Association. It compiles statistical experience, makes and files rates, and files and promulgates standard forms and endorsements for the following lines of insur-

[2] Another name is *audit bureau.*

ance: automobile liability and automobile physical damage, general liability, boiler and machinery, burglary, glass, residence water damage, residence explosion, and in some states, employers' liability and workmen's compensation. Its territory is national. The *Mutual Insurance Rating Bureau* performs much the same functions for mutual insurers.

The membership of the *National Council on Compensation Insurance* is composed of insurers writing workmen's compensation insurance, both participating and nonparticipating. It gathers data, makes rates, devises rating plans, and files rates and plans for workmen's compensation insurance with supervisory authorities in most states. It also administers the application of rates in many states. In some states *independent rating bureaus* perform these functions, each in its own state. These independent bureaus may be voluntary, as is the *New York Compensation Insurance Rating Board,* the oldest, or statutory, as are the bureaus in Indiana, Minnesota, New Jersey, and North Carolina. The voluntary independent bureaus were organized in many, if not all, of their states at the suggestion of the insurance commissioner.

Fire-insurance rating bureaus are regional or state. For example, the *Pacific Fire Rating Bureau* operates in Alaska, Arizona, California, Montana, Nevada, Oregon and Utah. Its membership is made up of stock fire-insurance companies doing business in that region; other insurers may subscribe to its services for any or all states. The *Fire Insurance Rating Organization of New Jersey* operates only in that state. The factory mutuals have their own rating bureau, but typically the fire mutuals are subscribers to bureaus operated by stock insurers.

The *National Insurance Actuarial and Statistical Association,* a stock insurer organization, collects and processes statistical data for use in rate making. The association does not make rates, but it develops statistical plans and processes the data in a manner that makes it most useful to rating organizations. At present the association limits its activities to fire, extended coverage, homeowners, and commercial multi-peril insurance, but it may concern itself with other lines later.

The *Fire Insurance Research and Actuarial Association* is a national advisory organization formed by stock insurers to coordinate the practices of local and regional rating bureaus and to conduct studies and research pertaining to fire and allied lines of insurance. Mutual insurers may become subscribers.

Inland-marine insurers have formed two bureaus, the *Inland Marine Insurance Bureau* and the *Transportation Insurance Rating Bureau,* the former stock, the latter mutual. Each promulgates rates and forms for certain lines of inland marine insurance.

The *Multi-Line Insurance Rating Bureau,* controlled by stock insurers, establishes rates for many of the newer multiple-line contracts.

Standard-forms Bureaus

Insurers in some lines and in several jurisdictions have found it profitable, in view of the complexity of statutory and bureau requirements, to provide for cooperative printing of endorsements and other forms. This provides standardized forms and reduction in printing costs.

Agents' and Brokers' Organizations

Except where the law prescribes particular qualifications, it is very easy to become an insurance agent. All that is necessary is to convince some insurer or special agent that the candidate can turn in a profitable line of business. If he is not competent or not conscientious in his business transactions, he may bring disrepute, not only on himself and his principal, but on insurance agents in general. In the absence of such prescription for brokers, the results may be similar.[3]

There are, in all the larger communities, associations of agents or brokers (sometimes separate, sometimes combined) doing a general insurance business, for the purpose of bettering their business life. The local organizations may be consolidated into state organizations and the latter into national. Among the outstanding national organizations are the *National Association of Insurance Agents*, the *National Association of Mutual Insurance Agents*, *The National Association of Insurance Brokers*, and the *National Association of Casualty and Surety Agents*.

These organizations aim:

1 To eliminate the unfit from the ranks of brokers and agents and to that end to secure strict qualification laws.
2 To eliminate part-time agents whose main business may be that of lawyer, apartment-house owner, bank official, or automobile dealer, and whose aim may be to secure the commission on his own, his family's, or his clients' insurance, or through the coercive power of credit to compel the placing of borrowers' insurance so that he will receive the commission.[4]
3 To secure for themselves what they believe to be proper treatment from insurers. A major part of the latter aim is continuance of the "American

[3] Agents' and brokers' qualification laws are discussed on pp. 554–555.

[4] Combination of an insurance agency with a real-estate business seems to be generally recognized as an established legitimate practice. Requiring negotiation of insurance through a particular agent or broker as a condition of making a loan on real or personal property is prohibited in certain states. See p. 556.

As noted on p. 322, as some insurers become department stores of finance, their agents become involved in diversified activities, but insurance remains their primary concern.

agency system," by which appears to be meant recognition of the agent as a quasi-independent businessman with a proprietary interest in the business he produces and ownership of expirations.[5]

The interests of life- and of health-insurance agents are represented by *The National Association of Life Underwriters* and by *The International Association of Accident and Health Underwriters*, as well as by various local and state organizations.

Prevention

Much work is done by insurers' organizations in the study of hazards and of prevention of loss. Outstanding among these organizations are the *Underwriters' Laboratories*, maintained by stock insurers, and the *Factory Mutual Engineering Division*, whose concern is with the special problems of that group. Both make careful and extensive tests of materials and equipment and approve products that meet their requirements. The *National Fire Protection Association*, whose purpose is the study of hazards and promotion of fire prevention, while not primarily an insurers' organization, receives financial support and cooperation from insurers and their personnel. The *American Insurance Association*, through its loss-prevention department, is concerned with accident hazards and prevention, particularly in connection with highway traffic.

Salvage companies specialize in reconditioning and selling damaged goods taken over by insurers, reducing the net loss to the insurer by minimizing the damage and by marketing the goods to advantage. Outstanding in this field are the *Underwriters Salvage Company of New York* and *The Underwriters Salvage Company of Chicago*, both owned by stock fire insurers, and the *United States Salvage Association, Inc.*, operated by marine interests.

Insurers not only protect the possible victims of crime under their contracts, but are themselves the direct targets of criminal activity in the making of fraudulent claims. In both cases, they are interested in defeating the purposes of the criminals and in combatting crime.

The *American Insurance Association* and a predecessor organization, the National Board of Fire Underwriters, have long fought incendiarism and arson and have more recently extended their prevention work to criminal loss and fraudulent claims under inland-marine contracts. The same association and another predecessor organization, the Association of Casualty and Surety Companies, have for many years investigated cases of fraud and unethical practices in personal-injury claims. When proof of fraud is developed, it is submitted for action to the appropriate prosecuting authority or, in the case

[5] See p. 395.

of professional misconduct, to the appropriate disciplinary body. The association operates a national index system of information on claimants for subscribers who contribute such information.

The *National Automobile Theft Bureau* is active in its field, and the *Security Bureau, Inc.*, concerns itself with unlawful practices, particularly theft and pilferage, on the New York waterfront.

Adjustments

While an insurer usually maintains an adjustment department, it is often advantageous to use a cooperative organization in the adjustment of losses. A loss may occur in a remote section or where the insurer writes only a small amount of insurance. An *adjustment bureau,* maintaining easily accessible adjusters available to give service to any insurer, can adjust such losses more economically and often more expertly than the insurer itself. They are also useful where several insurers are involved in the same loss. These bureaus deal chiefly with property losses. The *General Adjustment Bureau, Inc.*, operating nationally, is the principal one.

Underwriting

Many types of risk present such problems that insurers find it advisable to deal with them through specialized organizations. These problems are a mixture of hazards, prevention, rating, competition, underwriting capacity, and general administration. Among the types of risk so handled are nuclear energy, railway equipment, oil-producing plants, high-grade factories, risks owned by a single insured but at several locations, aviation, cotton, and grain.

Two groups of insurers, the *American Foreign Insurance Association* and the *American International Underwriters Corporation,* have extended the operations of American insurers throughout the world. They operate through branch offices and representatives.

Assigned-risk plans[6] are operated by the insurers writing insurance in the fields to which they are applicable.

Insurers often combine for the purpose of pooling their own reinsurance or for writing reinsurance for others.

Numerous organizations accumulate information on individual persons and risks and supply it to insurers. Among these are the *Medical Information Bureau* of the life insurers, which maintains records of medical impairments and of other adverse factors bearing on insurability—subsequent improvements are also recorded. The American Insurance Association has a file of

[6] See pp. 467–469.

reports on fire losses paid by its member companies, with comments on factors of underwriting interest. There are also several proprietary organizations that furnish underwriting information to insurers, either currently as it is accumulated or on request for a fee.

Legislative and Other Governmental Activities

Every year a multitude of bills affecting insurance is introduced in state legislatures and in Congress. These bills range all the way from those of direct concern to insurers, such as those providing for taxing insurers, regulating their investments, changing the pattern of rate regulation, or defining their powers, to those of incidental concern, such as those affecting prices or rates of interest. Legislative committees make investigations and recommend action; individual legislators make speeches and head movements; governmental departments and officials make investigations, raise questions, and propose courses of action.

On behalf of their members, various organizations gather information on what is going on in legislative and other governmental circles and may appear or arrange appearances before legislative committees or confer with officials. *Ad hoc* committees may be formed to express the opinion of insurers on specific questions, such as compulsory automobile insurance. On occasion, an agency of government will request advice or information from these organizations.

Operating on a national scale and a continuing basis are the *Life Insurance Association of America* and the *American Life Convention*, representing life insurers; the *American Mutual Insurance Alliance*, representing mutual insurers other than life; the *American Insurance Association*, representing stock insurers writing property and liability insurance; the *Health Insurance Association of America* (stock and mutual); the *National Association of Independent Insurers* (all types); the *National Association of Insurance Agents;* the *National Association of Insurance Brokers;* the *National Fraternal Congress of America*, representing fraternal benefit societies; and the *Insurance Department* of the Chamber of Commerce of the United States, representing all types of private insurance interests. These do not exhaust the list, and it may be said that practically all organizations have some interest and exercise some influence in legislative and other governmental matters.

Public Relations

The pioneering (1933) organization primarily engaged in the public relations field is the *Institute of Life Insurance*, which, through advertising, publication of life-insurance data, and fostering of education in life insurance, aims to

develop an understanding of, and a favorable attitude toward, the life-insurance business. This organization justifies the use of the term "public relations," since a large part of its purpose is to bring to life insurers an understanding of public attitudes and to show them how they may adapt their methods to the needs and desires of the public. Organizations with similar purposes are the *Health Insurance Institute* (1956), representing the Health Insurance Association of America, and the *Insurance Information Institute* (1959), representing the principal organizations of stock insurers in fields other than life and health.

In many cases, "public relations" covers only, or largely, propaganda, a word used here in no invidious sense, since no one should object to insurers having opinions and trying to convince others, or should there be any objection to attempts to create a favorable public attitude toward insurance groups. Practically all insurance organizations are engaged in some sort of propaganda, specialized or broad, even though their main purpose may lie elsewhere. Some have "public relations" divisions.

Research

As in the case of propaganda, many organizations do research work, though interest in pure research or even in research for direct application has commanded small interest in insurance. The actuarial societies have contributed important studies that have had results in practical application, and the *Life Insurance Agency Management Association* has done fundamental and valuable work in sales methods and in the selection and management of salesmen. Often "research" has as its end support for a position already taken.

Educational and Professional Activities

The Actuarial Societies. The leading professional and educational organizations are the actuarial societies: the *Society of Actuaries,* whose members are principally interested in life insurance, though health insurance is a topic of increasing moment to them; and the *Casualty Actuarial Society,* which has extended its interest from casualty insurance to fire insurance and its allied lines. A new organization, the *American Academy of Actuaries,* has been formed, primarily by members of the two older societies, to include persons in all branches of actuarial work. Membership in the Academy is also conditioned upon the passing of certain examinations. Technical papers are presented at the meetings of the societies, discussions are held, and there is much interchange of opinion and information within the guild. These societies are educational in the enforcement of their standards for membership, requir-

ing demonstration by examination of a candidate's knowledge and understanding; first, for the grade of Associate, and beyond that, the grade of Fellow. Insurers and other insurance organizations recognize membership in these organizations as evidence of ability in the professional field of the actuary, though one may still set himself up as an "actuary" without benefit of such attainment.

Technical papers are presented at the semiannual meetings of the societies, discussions are held, and there is much interchange of opinion and information within the guild.

Other Professional Organizations. Many organizations in which membership is individual and based on professional interest, as is the case with the actuarial societies, have as their purposes discussion of problems, publication of papers and information, and in general advancement of their respective professions. The names of a few will indicate their areas of interest: *The Association of Life Insurance Medical Directors of America; Insurance Accounting and Statistical Association; International Association of Insurance Counsel; National Association of Independent Insurance Adjusters; Section of Insurance, Negligence and Compensation Law, American Bar Association.*

Local Insurance Societies. Commencing with the formation of the *Fire Underwriters* (now *Insurance Underwriters*) *Association of the Pacific,* in 1876, in San Francisco, local insurance societies have been organized throughout the country. Their purposes are maintaining libraries, offering educational courses, and providing a forum for discussion. They have devoted their activities principally to insurance other than life. The most active is the *Insurance Society of New York,* which sponsors the College of Insurance, a unique institution that awards a bachelor's degree, a master's degree, and professional certificates to students completing its programs. This society also maintains what is probably the finest insurance library in the world. Other centers of notable activity are Atlanta and Boston.

Examining Organizations. The *American College of Life Underwriters* sets examinations for life-insurance agents, or successful completion of which and on satisfaction of certain other requirements, the designation of *Chartered Life Underwriter* is awarded. While the College conducts no courses, it suggests outlines of courses preparatory for its examinations, encourages the offering of such courses, and assists in development of educational methods. The

College also suggests a study program and conducts examinations in life-insurance-agency management and other special areas.

The *American Institute for Property and Liability Underwriters* performs the same functions as the College in the field of insurance other than life. It awards the designation of *Chartered Property Casualty Underwriter* to successful candidates, principally agents, brokers, and employees of insurers.

The *Insurance Institute of America* was once the leading examining body and a federation of the principal local societies, granting the designations of Fellow and Associate. It is now operated in coordination with the American Institute and devotes much of its attention to conducting elementary insurance examinations, on the successful completion of which it awards the *Insurance Institute Certificate.* This program is designed to provide a general understanding of insurance and to prepare for entering the program of the American Institute. It also conducts special educational programs for adjusters and for risk managers.

The *Life Office Management Association Institute* performs for employees of life-insurance home offices and field offices much the same functions as does the American College for agents. It awards the designations of Associate and Fellow.

The Insurance Company Education Directors' Society. The Insurance Company Education Directors' Society is an organization of employees of insurers who are actively engaged in educational work for insurers. Insurance teachers in colleges or universities may be Associate Members. The purpose of the Society is "the growth and professional development of its members to the benefit of their respective companies and the industry as a whole through research and exchange of ideas related to education and training."

The American Risk and Insurance Association. University teaching in insurance began about 1904 and, since 1920, has made great headway. In 1932, the American Association of University Teachers of Insurance was formed as an academic forum for the exchange of ideas and to promote insurance education and research. In 1961 this organization was renamed the American Risk and Insurance Association in order to emphasize its broad interest in risk and its treatment. Members of the association include all persons interested in risk and insurance education, but all of the officers must be insurance teachers in colleges or universities.

The general, as distinguished from the specialized, purposes of organizations such as those described in this chapter may be economy, accomplish-

ment of tasks not possible or impracticable for individual insurers or persons, standardization, or discussion of problems. At times individual insurers lean too heavily on rules and on efforts of the organization, but organizations are necessary, though it is felt by many that a considerable amount of pruning and consolidation might be in order.

Though each organization was formed for a stated purpose or purposes, there is considerable overlapping of function, and many organizations have specialized divisions and have extended their operations beyond their original purposes. The types of organization and the specific examples are intended only to give the reader a general notion of their variety and character.

QUESTIONS

1 What do you believe is the proper role of rating bureaus?
2 For what other purposes than developing rates have insurers organized cooperative organizations?

5
INSURANCE AND GOVERNMENT

The preceding parts of this text have dealt with the business of insurance—its functions, methods, and problems—from the point of view of the insured and the insurer.

Part 5 is concerned with the relation of government to insurance, under the heads of supervision and social insurance.

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THEORY AND DEVELOPMENT OF GOVERNMENTAL SUPERVISION

Every state has a body of law especially applicable to insurance and assigns to a state official (or board) the administration of the law. The official is usually called the Insurance Commissioner or Superintendent of Insurance; he heads the *state insurance department.* Insurance shares, with banking, public utilities, and transportation, the closest regulatory attention. The complexity of modern economic life is so great that the public tends increasingly to delegate to the state the investigation of those with whom it does business and the elimination of the unworthy, functions which, under simpler conditions, the individual performed for himself. The insurance business feels the effect of this development to a greater degree than most other branches of business.

NATURE AND PURPOSE OF SUPERVISION

Reasons for Supervision

Why is insurance subject to so much greater control than most other forms of business?

The basic reason for governmental supervision (or regulation) of insurance is found in the fact that the whole value of the promise sold to the public by insurers lies in future performance. Contract periods vary from 1 year (or sometimes less) to a lifetime. The obligations of the insurer may run for years after the original contract has terminated. In any case, the insured receives only a contract stating what the insurer will (or may) do under specified circumstances. If the contract is to be effective the insurer must be financially able to make good its promise whenever it becomes liable. Particularly in life insurance, the management that was in control of the insurer when the contract was written may not be in existence when the proceeds become payable, but the insurer must be a continuing entity.

To the extent that insurers' promises depend on the value of their investments or the return on them, the investments must be sound and yield an

adequate income. Since soundness often varies inversely with yield, the two qualities are somewhat opposed, and there may be a tendency to sacrifice one to the other. Soundness is of primary importance, since the possible loss through unsound investment may run to the full amount invested, while the sacrifice in yield is at most a percentage point or so.

Much insurance—notably life insurance, workmen's compensation insurance, and automobile liability insurance to the extent that it is required by the state—is written primarily for the protection of third parties who have little or no part in the making of the contract or the choosing of the insurer. They may not know who the insurer is (for that matter, many insureds are in the same situation) and have occasion to receive the proceeds or other benefits of the insurance as a rather remote consequence of the insured's choice. In the case of insurance required by the state, the insurer is acting as an agency of the state to make effective a social objective.

The public, even in its more knowledgeable segments, is generally ignorant of the meaning of insurance terms, the basic principles of the business, and the significance of insurance contracts, rates, and financial statements. People do not understand insurance methods, nor how to think about their insurance problems. Certain highly specialized insurance techniques would always be beyond the knowledge of the layman, particularly its mathematical calculations. While much that is now Greek to the public is not beyond the possibility of general understanding, the very language of insurance seems to be a barrier that causes many persons to abdicate when insurance questions, even those affecting their personal or business affairs, are up for discussion.

The costs (to insurers) that premiums are intended to cover are incurred after the price of insurance is fixed, often long after. Ability to meet these costs, the largest part of which covers the fulfilling of promises to insureds, or through insureds to beneficiaries, is in the long run dependent on collecting adequate premiums. But the remoteness of the costs is a temptation to overoptimism or unwarranted chance taking, particularly in the case of new or expanding insurers who are eager to attract business and who are inclined to turn to lower prices as a means. Since there is a considerable lag between collection of premiums and paying the costs they are supposed to cover, the consequences of charging inadequate rates may be considerably delayed. If inadequate rates continue to be charged, the effect is cumulative. Hence the paradoxical need to see to it that the insurer charges, and the insured pays, prices that are not too low.

Abuses—Actual and Potential

The arguments in favor of close governmental supervision of insurance might never have produced the degree of supervision that exists today if there had not occurred some serious abuses in the conduct of the business, particularly

in its early history. It is well, therefore, to consider at this point some of the opportunities for abuse, which supervision is intended to eliminate, and some examples of abuses before legislation and supervision closed the door.

The earliest abuse, for which special legislation was provided even in medieval Europe, was the drawing of improper contracts. There were unfair practices in drafting fire-insurance policy forms before standard forms were prescribed. There were unfair provisions in life-insurance policies prior to 1906 and similar abuses in personal-accident insurance. The contract is one phase of insurance in which abuses preventable by supervision are possible and have occurred.

Closely akin to abuses in drawing contracts is failure to carry them out in good faith, or unfair discrimination against persons who cannot afford the expense of legal proceedings. Nowhere is the insurance commissioner's office a legal-aid bureau to assist the needy in prosecuting actions against insurance companies, but the power of supervision and publicity can do and has done much to curb unfair treatment, and if to that is added the power of exclusion from future operations, such misconduct is likely to be much less frequent.

Failure to make proper provision for paying losses through adequate reserves is an abuse that only careful scrutiny of reports and examination of records can disclose. Such scrutiny and examination must often be by competent technicians before it can be known whether the reserves are adequate.

Improper investment of funds, or even reckless speculation, is possible if the management of an insurer is unskillful or corrupt, unless suitable safeguards are prescribed, with adequate examination and other supervision to enforce them. Many examples of such misconduct could be cited from the records of insurers whose unworthy careers are happily over.

There are, of course, many insurers whose establishment antedates the practice of any substantial supervision and whose records are unsullied by any of these practices. This might have been expected, as such abuses naturally lead to failure. High ideals of management are a better safeguard than state supervision. But in a competitive world high ideals sometimes have hard sledding. Honestly conducted insurers find in close supervision a considerable measure of defense, even though some expense or trouble in making reports and undergoing examinations may be involved.

Purposes of Supervision

Solvency. The prime purpose of governmental supervision is *solvency*, the continuing financial ability of insurers to meet their contractual obligations. Nothing is so important to the insured or, in fact, to the insurer itself. In the one case, solvency means ability to deliver to the insured (or a beneficiary) what he paid for; in the other, it means ability to continue as a going concern.

Protection of the insured, however, comes first; protection of the insurer is incidental.

Practices. An insurer might be thoroughly sound financially and yet indulge in practices inimical to the public interest. It might write unfair contracts, deceive its insureds, indulge in sharp practice in settling claims, or favor some of its insureds at the expense of others. Regulation of *practices* is the second most important function of a state insurance department. Here again both insureds and insurers are benefited. Insureds receive fairer treatment than would otherwise be the case, and well-managed insurers dealing equitably with their insureds are less subject to improper competition.

Competence. The newest and least developed field of supervision is *competence*—ability and character of sufficiently high grade to justify confidence. At one time, the holding of an agent's or broker's license meant merely that the middleman had paid the required fee to the state. Public and independent adjusters and insurance counselors could set themselves up as experts and offer their services under the principle of *caveat emptor.* A gradually developing sense of governmental responsibility is accepting the principle of protecting the public at the points where insurance touches the insured most intimately—planning insurance, buying insurance, and adjusting losses.

Professor Spencer Kimball, a noted authority on insurance regulation, has observed that the goals of insurance supervision are diverse and not always consistent with one another. As goals relating directly to the internal working of the insurance business he cites solvency—the most important goal and *aequum et bonum*—a term that implies fairness, reasonableness, equity, parsimony, and morality. As external goals imposed by society in accordance with its larger purposes, he cites democracy, liberty, local protectionism, federalism, socialization of risk, and freedom of enterprise. He also stresses the importance of separating the goals of regulation from the means of regulation.[1]

General Considerations

One of the problems of regulation of practices in particular, and of regulation in general, is to give insureds the benefit of protection against unfairness and dishonesty, without depriving them of the benefits of competition in service and prices. Rigidity is a danger of state regulation. Laws once enacted are

[1] Spencer L. Kimball, "The Goals of Insurance Law: Means Versus Ends."

difficult to revise, and regulations of insurance departments once adopted and working are hard to change.

Legislation should set up standards rather than attempt minutely to regulate insurance, and for two reasons. First, the ability and method of legislatures are much better suited to the determination of broad policies than to the discussion and adoption of detailed rules. An objective to be attained can be understood and intelligently debated by the widely differing individuals who make up a legislative body; it can be made the subject of compromise without destroying its essential character. Second, broad policies retain their validity over longer periods than do the rules for applying them. Let the legislature specify ends to be achieved, but leave the formulas for achieving those ends to administrative action. For example, insurers should be required to maintain assets to offset the present value of their expected losses, but the determination of values, both of assets and losses, should be left to administrative experts.

Wherever possible, without opening an inviting path to dishonesty or incompetence, and always subject to conformity to established general principles, insurance should be left free to develop new ways of serving the public. In the field of contracts there is a tendency for regulation to add to its negative function of preventing unfairness the positive one of seeing that the insured gets advantages that he should have. If this tendency continues, and insurers are encouraged to experiment in the broadening of coverage and the liberalization of conditions, insurance will be able more completely and economically to fulfill its functions. The key to sound and liberal regulation of insurance is to take the point of view of the insured, which means in turn to keep in mind the situation when losses occur. And this should be the aim alike of legislator, administrator, and management.

Publicity Alone Not Sufficient

Prior to the establishment of state insurance departments charged specifically with the regulation of insurance, reliance was placed upon publicity of accounts as a means of protecting the public. The establishment of state insurance departments indicates that publicity alone did not protect. Since publicity of accounts has long been the substitute for regulation in Great Britain,[2] whose insurance institutions are recognized throughout the world as of the highest standing, it is well to consider why that system will not work well in the United States.

[2] Under the Winding Up Acts, 1933 and 1935, the Board of Trade is given power of investigation under certain circumstances to determine solvency. These acts and later legislation seem to indicate a trend in British thinking toward more positive regulation, a trend brought about by occasional failures.

In Great Britain, the manager's freedom of judgment in setting up reserves and handling finances is accompanied by a rigorous enforcement of responsibility for the truth of reports filed with the Board of Trade. This is the form of publicity that applies not only to insurance but to all corporate enterprises. It does not appear that any such rigid enforcement of responsibility for truthfulness in reports was characteristic of American practice when publicity was tried as a regulator. Perhaps the precariousness of all enterprises in a pioneer country, the difficulty of establishing bad faith, and the general tendency to view charitably the mistakes of the honestly intentional explain this laxity. But it seems indisputable that strict accountability for untruth in reports is a *sine qua non* if publicity is to protect.

In the second place, the difference in temperament of the two peoples must be considered. The British are traditionally conservative, patiently and painfully investigating before entering into a business transaction, and sticking to established connections in the presence of apparently tempting advantages in change. The winning of the new continent required the American to "take a chance." If he lost, he charged it up to experience and tried again. Time was too precious to waste in trying to understand the details of an intricate balance sheet, and it was too costly to employ an expert to do it for him. This era in American business is perhaps, with increasing integration, passing, but in the meantime the policy of close governmental supervision has become so well established that a change in business practices is not likely to cause its abandonment.

DEVELOPMENT OF INSURANCE REGULATION

Regulation of Marine Insurance in Medieval Europe

The attitude of the medieval church toward usury was a handicap to the growth of insurance, since the church classed insurance, as well as the payment of interest, among transactions in which payment was exacted without the rendering of visible service. It is said that a papal decree of 1227 prohibited bottomry loans, the precursor of the modern insurance contract.[3] It was also regarded as immoral to insure, as presuming to interfere with the decrees of God. Despite these difficulties, however, the needs of commerce forced recognition of the practice. Its abuse for gambling purposes and in commercial rivalries led to the first regulatory legislation. Genoa, in the last quarter of the fourteenth century, passed an ordinance designed to prevent insurance on foreign ships.

[3] F. L. Hoffman, "Insurance Science and Economics," p. 145.

The earliest known insurance code was promulgated at Barcelona in 1435. It was apparently in response to the second purpose of regulation noted above, for it contained rules of conduct for insurers and provided that those "who write policies shall be bound to see that they are properly drawn." The problem of securing the solvency of the insurer at the time of loss does not seem to have been dealt with, perhaps because the insured were generally merchants accustomed to investigate the credit of those with whom they dealt. Florence, in 1532, provided for appointment of commissioners to regulate the practice of marine insurance in many details, including rates. There was similar regulation in other cities of continental Europe.

Governmental Regulation in England and Her Colonies

The early traders in England, being foreigners, did not usually resort to the constituted courts but seem to have regulated their own practices. Thus there was little occasion for governmental action in insurance matters, although an official registrar of insurance contracts was appointed about 1574 and given a private monopoly, and a special court for trying insurance cases was set up in 1601.[4] The registration office seems to have been ignored, and the court had little influence on the development of the business. Until the time of Lord Mansfield,[5] insurance disputes rarely came into the English courts. The first English insurance corporations were chartered in 1720 and were given a monopoly of corporate underwriting of marine risks. The monopoly lasted a century. Aside from this monopoly and statutes against wagering, governmental regulation of insurance did not exist in England or her colonial dominions in America prior to the War for Independence.

Beginnings of Regulation in the United States

There are records of insurance in colonial times by individuals after the manner of Lloyd's underwriters, but aside from one or two local mutual fire-insurance companies and the Presbyterian Ministers' Fund, issuing survivorship annuities, there were no organized insurers in existence. However, beginning with the incorporation of the Insurance Company of North America (which had commenced doing business in 1792) by act of the Pennsylvania Legislature, Apr. 14, 1794, the close of the eighteenth and the beginning of the nineteenth centuries witnessed the incorporation of a number of insurers.

[4] 42 Eliz., chap. 12.
[5] Chief Justice of the King's Bench, 1756–1788.

These were all incorporated by special charters granted direct by the legislatures, and although these charters were by no means uniform, they generally contained some regulatory provisions. These provisions dealt with the capital of the corporation and the manner of investing its funds and frequently required reports, either to the legislature or to some designated state official, such as the secretary of state, treasurer, or comptroller. Sometimes a deposit of securities with a state official was required. A frequent provision was a requirement for periodic publication of reports of financial condition. No official was regularly charged with the duty of examining these reports or the practices of the companies until much later. The intent seems to have been to provide a means by which interested persons might inform themselves. Presumably, it was thought that the avoidance of unsound insurers by prospective customers would automatically cause the failure of such corporations, and that anyone discovering fraud would make complaint to the usual officers of the community charged with suppressing crime. This attitude was in accordance with the individualistic spirit of the times.

There was, however, interference in one respect in several of the states early in the nineteenth century. Pennsylvania and South Carolina, in 1810, and New York, in 1814, enacted statutes prohibiting under severe penalties the writing of insurance for insurers of foreign countries. The apparent motive for these enactments was less the protection of the citizens than enmity toward the British, who were the leaders in the business of insurance.

Taxation and Licenses for Revenue

Since an insurer must always develop considerable revenue and accumulate a substantial amount of assets, it was inevitable that these revenues and assets would attract the attention of officials seeking revenue for the state. In 1824, New York imposed a tax of 10 per cent on the premiums received in that state by fire-insurance companies incorporated in other states.[6] New Jersey began taxing premiums in 1826. As early as 1830, Connecticut began taxing the stock of domestic insurers. And in the decade 1841 to 1850, several of the states began requiring the licensing of insurance agents and charged a fee therefor. All such taxation measures required periodic reports for the purpose of determining the tax. The returns were made to a financial officer of the state. Where agents paid a license tax and insurers of other states were represented, it was a natural transition to require some sort of showing as to the financial condition of the insurer.

[6] Reduced in 1837 to 2 per cent and applied to marine companies as well.

General Incorporation Statutes and Special Commissions

By the middle of the nineteenth century, several of the states had enacted general incorporation statutes covering the several classes of insurer, and incorporation by special legislative enactment was discontinued in those states. These general statutes provided for filing certain papers with state officials, the minimum amount of capital required, and the manner of its investment. But at that time there was in no state an official charged with the exclusive duty of regulating the insurance business or enforcing the insurance law. There were provisions for special examinations at the instance of the courts, and the state treasurer, comptroller, or other official might scrutinize the company reports, if he found time from his other duties. But it was not systematically done nor expected. The next step was the establishment, in certain states,[7] of commissions whose duty it was to examine the reports of insurers and to endeavor to exclude the insolvent. These were generally ex-officio boards, and where the duties of the office of each member absorbed his major interest, nothing of importance could be expected.

Beginnings of Insurance Departments—Elizur Wright

The beginning of modern supervision is usually associated with the appointment, in 1858, of Elizur Wright as one of the two insurance commissioners of Massachusetts. Prior to that time, Massachusetts had tried an ex-officio board, and for 3 years a per-diem board, but, in 1858, changed to two full-time salaried commissioners. New York, in the next year, established its separate insurance department, presided over by a superintendent, whose position is now the most important and influential in the field of insurance supervision, although the traditions and standards of the Massachusetts department give it very high standing.

Elizur Wright and George W. Sargent were insurance commissioners of Massachusetts for 8 years, but Wright was the dominant personality. Their reports, especially those dealing with life insurance, may properly be called classics, not alone for their clear exposition of the important problems of the day and of the fundamentals of life insurance, but also for the vigor of their style and the firmness with which abuses were denounced and remedies proposed. Any student of life insurance or governmental supervision of corporate activity will be well repaid for the time spent in reading them.

Wright had succeeded in having enacted, effective concurrently with the law establishing the department, a statute requiring life insurers to report the

[7] New Hampshire, 1851; Massachusetts and Vermont, 1852.

particulars necessary for a determination of the reserve on a net-premium basis, and requiring the commissioners to calculate the reserve, allowing them to determine the mortality table and rate of interest for this purpose. The application of this test showed one prominent British insurer to be insolvent. In the controversy that followed, the company employed eminent actuarial and mathematical talent in its defense. But Wright, with the support of the better American insurers, exposed the fallacy of its position. From this beginning has developed the present requirement in all states of net-premium reserves (though with some modification to meet changed conditions in regard to expense) as a test of solvency for life insurers.

Wright also secured the passage, in 1861, of the Massachusetts nonforfeiture law, which requires life insurers to grant surrender values in event of failure by the insured to pay a premium when due, a requirement which has also become universal.

Other contributions of this great reformer were the precedent of published reports containing the financial statements of the insurers and illuminating comments on conditions in the business, and the example of a vigorous administration of the office of insurance commissioner.

National Association of Insurance Commissioners

Following the precedents in New York and Massachusetts, separate insurance departments were established in several of the states during the next decade. With the institution of something more than merely formal supervision in these states, conference between commissioners became essential to prevent conflict in requirements and needless confusion. Cooperation became especially important as means of communication improved and insurers extended their business over several states. In 1871, the National Convention (now Association) of Insurance Commissioners was formed, and it has met at least annually since that time. This is an extralegal conference composed of the insurance commissioners (or corresponding officials) of all states.

Although there is still great diversity in the insurance codes of the several states, the Convention and its successor, the Association, have done much to promote uniformity in special laws[8] that have been recommended by it to deal with particular problems, and unity of action in examinations of insurers and their organizations. Its greatest accomplishments have probably been securing uniformity in the forms in which reports and financial statements are required, valuation of securities, and adjustment of state regulation to the situation created by the SEUA decision.

[8] E.g., the laws providing for standard provisions in health-insurance contracts and the uniform fraternal-insurance law.

Armstrong Investigation of 1905

During the latter part of the nineteenth century certain of the large mutual life insurers, particularly those of New York City, issued *tontine*, and later *deferred-dividend*, policies under which no dividends to policyholders were paid until after a certain time[9] from the issue of the policy. The total fund, including the shares of those who had lapsed or died, and in the earlier forms including the amounts of the reserves on the policies of those who lapsed,[10] was to be divided among the survivors. This appealed to the gambling instinct, and the policies were sold as speculations as much as, or more than, insurance contracts. No accounting being called for during the deferment period, huge sums were left in the hands of the insurers, for which, for the time being, they were accountable to no one. This led to a race for size, the use of high-pressure sales methods, extravagant commissions, and frequent misrepresentation.

"Strike" bills against life insurance were introduced in legislatures, and bribery of legislators was concealed as "legal fees." The officers of some of the insurers participated in underwriting syndicates for floating securities, selling a large part of the securities to their own companies and reaping substantial profits. In some insurers, sinecure jobs were provided for relatives of officials, or lucrative agency contracts were given them.

A quarrel among the interests in control of one insurer attained such public notice as to bring on an investigation by a committee of the New York Legislature, under the chairmanship of Senator Armstrong, with Charles E. Hughes (later Chief Justice of the Supreme Court of the United States and a candidate for President of the United States) as counsel. The abuses just noted were disclosed by that investigation. As a consequence, the regulation of life insurance in New York, and in many other states, was made much stricter, and the personnel of the insurance departments reorganized and strengthened.

Among the new requirements of life insurers in New York was inclusion of the proceedings of each insurer's annual meeting in the annual report to the department. The names of all officers, and of others receiving more than $5,000, except in payment of a policy claim, during the year, the amount paid them, and the authority for it were required to be reported. The basis of reserve was modified to meet modern conditions, the amount of new business that might be written annually was limited, and definite maximum limitations on total expense and on expense of procuring new business were set.

[9] Five years or more under deferred-dividend policies; when the premiums, accumulated at interest, reached a specified amount, under tontine. *Semi-tontine* policies were a variant of tontine.

[10] Special agreements were signed waiving the statutory nonforfeiture provisions until this was forbidden.

Deferred-dividend policies were forbidden, annual dividends were required if earned, and standard policies were required. Restrictions on investments were tightened. A limit was set on the amount of surplus that might be accumulated. Some of the regulations were too drastic, for public opinion was much aroused, and some have since been modified,[11] but on the whole the results have been decidedly beneficial. As bearing on the development of the present form of insurance supervision, the result to be noted is a considerable increase in statutory requirements and in administrative authority.

As a direct result of the Armstrong Investigation and the recommendations of the committee, a conference of state officials at Chicago appointed, on Feb. 1, 1906, the Committee on Uniform Legislation (the "Committee of Fifteen"). The recommendations of this committee followed closely those of the Armstrong Committee and led to a large measure of uniformity in the life-insurance laws of the various states.

Investigation into Health Insurance, 1910–1911

In the course of an examination by the New York Insurance Department of an insurer conducting a health-insurance business, largely among the poorer classes of working people, reprehensible practices were discovered. The matter was so serious that it was taken up with the executive committee of the National Convention of Insurance Commissioners.

> A committee of this Convention was accordingly appointed which made an investigation of fourteen or fifteen companies. Their time was limited, since they wished to report to this Convention, but the disclosures made by them were shocking in the extreme. Instead of basing the adjustment of claims upon equitable principles, some of the companies examined resorted to every form of trickery and deceit and even forgery and theft in order to escape their honest obligations. This was all the more outrageous in view of the fact that these frauds were perpetrated upon the poorer classes who, in the very nature of things, should be given every possible protection.[12]

The action of the Convention, and of most of the individual commissioners, was vigorous, and the permanent result was the enactment in most states of a uniform law providing for standard provisions in health-insurance policy forms,

[11] E.g., substitution of standard-provision requirements for standard forms, giving power to the Superintendent of Insurance to waive the limitation on new business, and broadening the field of investment.

[12] From presidential address of F. W. Potter, Superintendent of Insurance of Illinois, opening 42d Session, National Convention of Insurance Commissioners, at Milwaukee, Wis. Aug. 22, 1911. *Proceedings of the National Convention of Insurance Commissioners*, vol. I, p. 14, 1911.

and the prohibition of the use of any such form until it had been submitted to, and approved by, the insurance commissioner.

Fire-insurance Rates and the Merritt Committee Investigation of 1910–1911

Prior to 1909, insurance commissioners had no power to regulate or to make rates. The theory in most states was that competition was the proper regulator of prices and that free and open competition should be allowed, and even forced, to function. Three types of law are indicated by this theory as necessary and desirable:

1 A law against combinations for control of rates—an *anticompact* law
2 A law forbidding unfair discrimination in rates—an *antidiscrimination* law
3 A law forbidding division of an agent's commission with the insured, or giving the latter any other special consideration or gift—an *antirebate* law

Laws of each type have been enacted in nearly all the states and still appear on the books of some, but those of the first type have been displaced by laws providing for positive regulation, as it has come to be realized that combination of experience is necessary to sound rate making. Kansas, in 1909, enacted a law requiring the filing of fire-insurance rates with the Superintendent of Insurance and giving him a veto power on rates as filed. The constitutionality of this statute was tested in the Supreme Court of the United States, in connection with his first act under that law, and was sustained.[13]

Criticism of fire-insurance rates in New York led, in 1910, to the appointment of a legislative investigating committee under the chairmanship of Senator Merritt. Their report contained an excellent discussion of the problem of fire-insurance rates, including the problems of fire prevention as affected by insurance rates, and of the relation to rates of the ratio of insurance to value. Their recommendations, as embodied in the New York law, became a precedent for several states. Under this system, an insurer was permitted to belong to, or subscribe to, a rating organization and to adhere to its rates, or to file its own rates and adhere to them. The superintendent supervised these organizations to prevent unfair rates and examined them periodically.

Insurance as Commerce

Before the systems of supervision of insurance by the several states had become as elaborate as they now are, and when the requirement of licenses was primarily for the purpose of state revenue, a case[14] arising out of refusal

[13] *German Alliance v. Lewis*, 233 U.S. 389 (1914).
[14] *Paul v. Virginia*, 8 Wall. 168 (1869).

of an agent of a New York insurer to procure a license in Virginia was carried to the United States Supreme Court. It was contended that the requirement was in contravention of two clauses of the Federal Constitution, one giving the citizens of each state all the privileges and immunities of citizens in the several states, and the other giving Congress power to regulate commerce among the states. It was held that corporations are not citizens within the meaning of the first clause, and that insurance is not commerce within the meaning of the second. This doctrine was upheld in a number of other cases, the latest in 1913.[15]

Since the right of the federal government to regulate business is dependent on the commerce clause of the Constitution and since insurance was held, over the years, not to be commerce, the federal government had no power to regulate insurance. That power remained in the states, subject only to their own constitutions and courts.

In 1942 the South-Eastern Underwriters Association (SEUA), a fire-insurance rate-making body, its member companies, and many individuals connected with it were indicted for violation of the Sherman Antitrust Act. The trial court sustained a demurrer based on the previous decisions of the Supreme Court, and the government carried the case to the Supreme Court. Two of the justices of the Supreme Court disqualified themselves. Of the remaining seven, four held the indictment valid, and one other agreed that insurance is commerce and, when it crosses state lines, interstate commerce. Two, dissenting from the majority opinion, nevertheless held that insurance affects commerce. The Court was in complete agreement on the power of the federal government to regulate insurance, either as interstate commerce or as affecting interstate commerce, as was also shown by their opinion handed down on the same day in another case.[16]

> On the question of whether the Sherman Act applies to insurance the difference in views was sharper. The majority view was that Congress intended the Act to apply. The minority view was that Congress had no such intention. The majority view seems to have been based upon the fact that Congress did not make an exception of insurance when it enacted the Sherman Act. The minority based its view upon debates in Congress which indicated that Congress considered insurance outside the scope of the Sherman Act because of earlier Supreme Court decisions.
>
> The disposition of this question and the views of the majority and minority of the Court are no longer of significance because Congress has

[15] *New York Life Insurance Company v. Deer Lodge County,* 231 U.S. 495.
[16] *Polish National Alliance v. National Labor Relations Board,* 322 U.S. 643 (1944).

since enacted a law which affirmatively applies the Sherman Act to the business of insurance.[17]

Public Law 15

Leaders in Congress promptly denied that it was the intent of the federal government to overthrow the established system of state supervision but insisted that if the Sherman Act and other antitrust acts were to be inapplicable, the states must regulate the practices that these acts forbid. Congress enacted Public Law 15, which was approved on March 9, 1945, and which reads as follows:

> *Be it enacted, etc.,* That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.
>
> Sec. 2. (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several states which relate to the regulation or taxation of such business.
>
> (b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically relates to the business of insurance: Provided, That after January 1, 1948, the act of July 2, 1890, as amended, known as the Sherman Act, and the act of October 15, 1914, as amended, known as the Clayton Act, and the act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.
>
> Sec. 3. (a) Until January 1, 1948, the act of July 2, 1890, as amended, known as the Sherman Act, and the act of October 15, 1914, as amended, known as the Clayton Act, and the act of September 26, 1914, known as the Federal Trade Commission Act, as amended, and the act of June 19, 1936, known as the Robinson-Patman Anti-discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.
>
> (b) Nothing contained in this act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.
>
> Sec. 4. Nothing contained in this act shall be construed to affect in

[17] Elmer Warren Sawyer, "Insurance as Interstate Commerce," p. 45. The case citation is *United States v. South-Eastern Underwriters Association et al.*, 322 U.S. 533 (1944).

any manner the application to the business of insurance of the act of July 5, 1935, as amended, known as the National Labor Relations Act, or the act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the act of June 5, 1920, known as the Merchant Marine Act of 1920.

Sec. 5. As used in this act, the term State includes the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

Sec. 6. If any provision of this act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected.[18]

Effects of the South-eastern Underwriters Case and Public Law 15

Public Law 15 and the extension of the moratorium (1) announced that Congress did not intend to exercise its new-found right to regulate insurance and that it considered regulation by the states to be in the public interest; (2) confirmed the right of the several states to regulate and tax insurance; (3) exempted insurance from the application of specified federal laws to June 30, 1948; (4) applied the specified laws and the Robinson-Patman Act to insurance after June 30, 1948, to the extent that the business "is not regulated by State law"; (5) applied the Sherman Act without qualification to "any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation"; and (6) left in full force, as to insurance, the laws specified in Sec. 4.[19]

Certain practices and agreements which it was felt might come under the head of boycott, coercion, or intimidation were almost immediately dropped by the insurance business. Notable among these was "separation," the practice of a certain class of insurer that refused to do business with agents who represented insurers of other classes. Others have been discontinued as the result of consent judgments.[20] Another of these practices that have been investigated by the United States Department of Justice is the requirement by some lending institutions making secured loans that the borrower purchase insurance on the security from agents or insurers selected by the lender.[21]

[18] The application of Sec. 3(a) was later extended to June 30, 1948, and the proviso in Sec. 2(b) was amended to conform to the extension.

[19] The Merchant Marine Act of 1920 had exempted marine insurance and reinsurance from the application of the antitrust laws.

[20] Two famous cases are *United States v. Insurance Board of Cleveland*, 144 Supp. 684 (1955); 188 F. Supp. 949 (1960) and *United States v. New Orleans Insurance Exchange*, 148 F. Supp. 915, affirmed, per currion, 355 U.S. 22 (1957).

[21] *United States v. Investors Diversified Services*, 297 CCH Trade Cases 116, Section 69, 574 (1954).

The chief concern of state insurance officials and of insurers was the fact that fixing prices in concert was *ipso facto* a violation of the Sherman Act, which would again apply to insurance after June 30, 1948. It was evident that making insurance rates through bureaus operated by insurers without regulation was a violation of the Sherman Act. An All-Industry Committee, representing fire, life, and casualty insurers, working in cooperation with the National Association of Insurance Commissioners, devised and recommended bills for introduction in state legislatures that provided for authorization and regulation of rate-making organizations. The principles of these bills, which were enacted into law with or without modification in most states, apparently satisfied the legal requirements of Public Law 15, but there is some question whether the system of regulation that has developed is satisfactory.[22]

All states have also adopted some version of a model unfair-trade-practices act approved by the National Association of Insurance Commissioners shortly after the passage of Public Law 15. These acts prohibit such practices as rebates; unfair rate discriminations; defamation of persons engaged in insurance; misrepresentations and false advertising; boycott, coercion, and intimidation; and filing false financial statements. Many states have laws regulating interlocking directorates, mergers, and acquisitions of one insurer by another.

There has been much discussion of what the states must do to meet the requirements of Public Law 15. This question may be approached from two points of view. The legal question of what "regulated by state law" means, in terms of ousting the application of the federal laws mentioned in the text of Public Law 15 (the Sherman Act, the Clayton Act, the Federal Trade Commission Act, and the Robinson-Patman Anti-discrimination Act), has now been almost fully answered by the decisions of the Supreme Court of the United States in *Federal Trade Commission v. National Casualty Company*[23] and *Travelers Health Association v. Federal Trade Commission.*[24] Both of these cases developed out of complaints the Federal Trade Commission made against many health insurers with respect to their advertising. This action was significant because it was the first attempt by a federal agency to test the adequacy of state regulation. In effect, the first decision holds that the existence of a state law regulating activities that would be affected by the federal law serves to displace the federal law even though the administration of the state law may be "inchoate." The second decision, dealing with a mail-order insurer, holds that the relevant state regulation required to displace the federal law is regulation by the state where the violation occurs, not regulation by the home state of its domiciliary's extraterritorial activities. In accordance with

[22] The subject of rate regulation is explored in some detail on pp. 550–553.
[23] 375 U.S. 560 (1958).
[24] 362 U.S. 293 (1960).

these decisions the Federal Trade Commission withdrew the advertising rules that it had intended to apply generally to health insurers, but, on the assumption that state regulation is not adequate in these areas, it has exerted its jurisdiction over mail-order insurers in states in which they are not licensed or in which they have no agents.[25] The adequacy of state regulation of mergers and acquisitions involving two insurers domiciled in different states has also been denied in some recent cases.[26] The variable annuity has been subjected to federal regulation because, in the court's opinion, variable annuities are not insurance contracts.[27]

These decisions, however, do not answer the major political question, since widespread failure on the part of the states both to create and to administer a comprehensive system of regulation based upon their own statutes would likely cause a reconsideration of that question. Congress remains free to consider anew, at any time, whether Public Law 15 should be repealed or modified. The only insurance activities beyond its reach are those of a strictly intrastate nature, if there be such.

The most concrete evidence of congressional interest in the adequacy of state regulation is the continuing investigation of the insurance business since 1958 by the subcommittee on antitrust and monopoly of the United States Senate Committee on the Judiciary. This subcommittee has studied various matters, including the nature and structure of rate regulation, ocean marine insurance, aviation insurance, rate regulation of property and liability insurance with particular emphasis upon the role of rating bureaus, the regulation of alien insurers, and the operations of substandard automobile insurers. In its reports it has been highly critical of state regulation and has suggested certain changes, but up to this time Congress has neither modified Public Law 15 nor indicated its intention to supplant state regulation in any significant degree.[28] Recent investigations of the automobile-insurance business by the Department of Transportation and the House antitrust subcommittee of the Committee on the Judiciary provide further indications of serious congressional interest in insurance.

[25] A recent decision by the Supreme Court of Wisconsin upheld a statute which provides for the regulation and taxation of unlicensed insurers doing business by mail. This decision is generally agreed to strengthen the role of the states. See *Ministers Life and Casualty Union v. Haase*, 141 N.W. 2d. 287 (1966). This decision has been affirmed by the Supreme Court of the United States.

[26] *United States v. Chicago Title and Trust Co. et al.*, 242 F. Supp. 56 (E. D. Ill., 1965).

[27] *Securities and Exchange Commission v. Variable Annuity Life Insurance Company of America et al.*, 359 U.S. 65 (1959). See pp. 321–322.

[28] "The Insurance Industry: Aviation, Ocean Marine, and State Regulation," *Report of the Subcommittee on Antitrust and Monopoly, 86th Congress, 1960*, pp. 1–2.

STATE VERSUS FEDERAL REGULATION

Since the decision of the United States Supreme Court holding that insurance is commerce, with the implied threat of federal regulation replacing that of the states, the relative merits of state and federal regulation have been much discussed. Those who favor state regulation argue that:

1 Conditions affecting risks in all fields vary widely from section to section.
2 Local authorities are familiar with local conditions and will recognize their importance more readily than the more remote federal authority in Washington. Thus local regulation will bring about greater equity than will central regulation.
3 The federal bureaucracy tends to be more rigid and arbitrary than does that of the states, while such uniformity as is desirable can be obtained through conferences of the local authorities in the National Association of Insurance Commissioners.
4 Pressure groups can maintain more effective lobbies in a single center at Washington than in each of the several states.
5 Regulation by the states permits comparison among different approaches. Furthermore, experimentation by a single state with a new approach is not too costly if the experiment turns out to be wrong.

It is urged, however, in favor of federal regulation that:

1 Notwithstanding Public Law 15, there remain certain aspects of the insurance business that are now regulated by federal statute,[29] and certain aspects as to which there is doubt whether the state police power or federal regulations apply. Exclusive federal regulation would remove the uncertainty as to overlapping.
2 Exclusive federal regulation would entail much less burden of expense on insurers by way of reports and other duties than in complying with state laws.
3 Conflicts in rulings on the same subject matter[30] would be less likely to arise.
4 Examination procedure would be simplified and uniform, though much has been accomplished toward that end by the zone system of examination under the supervision of the National Association of Insurance Commissioners.
5 Federal regulators could be more carefully selected and more highly paid. They would be less subject to local pressures.
6 Certain aspects of rate making are national in scope. For example, in

[29] E.g., relations with employees are subject to the Labor Relations Act.
[30] E.g., policy forms.

some instances, such as catastrophe windstorm losses, it is desirable to spread the risk nationwide. State regulators do not always accept this philosophy.

7 Many insureds have locations and operations in several states and desire single policies and rates. This is difficult to accomplish under state regulation.

8 It is desirable that there be considerable flexibility in insurance forms and practices to meet the needs of business under changing economic conditions. The system of state regulation, requiring in some cases the approval of more than one state authority, imposes considerable rigidity that might be less under federal control.

The regulation of insurance investments by the states has been on the negative side, e.g., prohibition of investment in securities not deemed eminently safe, but no compulsion that investments be diverted to uses approved by state policy. During the hearings of the Temporary National Economic Committee (1938–1940) there was considerable emphasis on the proposition that the country needed more venture capital, especially for the benefit of small business. It was intimated that the huge accumulations of the insurance business, particularly the life-insurance business, and the conservatism of its investment policies tended to restrict the amount of venture capital. This led some conservative insurance executives to fear federal regulation, lest theorists coming into federal bureaus in a liberal administration might attempt to improve the opportunities of small business by compelling insurance investments to flow into channels that these executives feel are unsuited for insurance funds. Of course, congressional action would be necessary. But they would have to oppose before Congress the recommendations of the government bureau and might easily be placed in an embarrassing position.

SUCCESS OF REGULATION

One still reads of failures of insurers and fraudulent practices of their officers; these are news. One hears much less of continuing financial soundness or of observance of laws and regulations. That regulation does not achieve perfect results is to be expected, for no system of laws, examinations, or enforcement can forestall the activities of all fraudulent or incompetent insurance practitioners. And there is considerable variation in the approach to adequacy of laws, insurance departments, and insurance commissioners.

One outstanding weakness is the turnover of commissioners, reflecting the political nature of their appointment in most states and the low salaries most

commissioners receive relative to their responsibilities. The effect of turnover is somewhat mitigated by departments equipped with high-grade civil-service staff who provide competence and continuity and serve to initiate and instruct the incoming commissioners. But many departments are inadequately staffed and are governed by inadequate laws; the number and quality of personnel have not been increased to match the vast enlargement of responsibility.

In spite of these conditions insurance regulation has been successful in achieving in high degree its purposes, to a considerable extent because an insurer, to be admitted to do business in a state, observes, in conducting its entire operations, the laws and regulations of that state in many vital matters. The state having the strictest regulation controls in large measure the destinies of insurers admitted to do business there but domiciled elsewhere.

QUESTIONS

1 What differences are there between insurance and manufacturing that have led to stricter governmental supervision of the former?
2 What is the prime purpose of supervision of insurance? What other purposes does it serve?
3 "The public would be better served if insurers were left free to compete for business without governmental restriction, but were required to file complete data on their financial condition and operations, which data would be open to public inspection." Comment.
4 What is the present regulatory relation of the federal government to insurance?
5 To what extent is governmental regulation of insurance necessary?
6 Would federal regulation of insurance be more desirable than state regulation?

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METHODS OF GOVERNMENTAL SUPERVISION

THE STATE INSURANCE DEPARTMENT

Most states have separate insurance departments; in several, the insurance commissioner is also the state fire marshal; in two, he is commissioner of banking and insurance; in one, he is comptroller; and in one, treasurer. In all states, the regulation of insurance is recognized as a specialized function. The insurance commissioner is assisted, in states where supervision is highly developed, by a considerable corps of specialists and clerical employees. He is usually appointed by the governor for a term not exceeding four years, though he is elected in some states. While politics has its influence, and is sometimes controlling, there are instances of commissioners retaining office by appointment by governors of different political faiths, and in many states ability is a major criterion. Occasionally a commissioner is a "career" man, advanced from the lower ranks of the department.

In New York, where one finds perhaps the most extensive body of insurance law and the most highly developed insurance department, the department is headed by the Superintendent of Insurance and several deputy superintendents appointed by the superintendent. There are two additional deputies who are career men in the department and under civil service. These deputies and over 700 other permanent civil-service employees give continuity to the operations and policies of the department. Among these employees are specialists in the various insurance fields: lawyers, actuaries, statisticians, and accountants.

FUNCTIONS OF STATE INSURANCE DEPARTMENTS

Enforcement of Law[1]

The insurance commissioner is charged, as an administrative officer, with enforcement of the insurance law, but not as the sheriff is so charged. He has no power to arrest and hold, although in some states, in cases of probable insolvency, where delay may cause irreparable loss, he may seize the assets and books of an insurer before petitioning the court for appointment as conservator. He

> may maintain and prosecute, in the name of the people of the state, an action against any insurer, its officers, directors, trustees or agents or against any broker or adjuster or against any other person or persons subject to the provisions of this chapter, for the purpose of obtaining an injunction restraining such person or persons from doing any acts in violation of the provisions of this chapter.[2]

The court may also, upon application of the commissioner, issue an injunction restraining the insurer and others connected with it from transacting business or wasting or disposing of its property.

In the case of an agent, broker, or adjuster, he may, in lieu of revoking or suspending his license,[3] levy a fine, on failure to pay which he may revoke or suspend the license. As to other money penalties for violation of the insurance law, he may maintain a civil action to recover a judgment.

While he has broad inquisitorial powers, he may not personally conduct the prosecution of one whom he considers to be an offender under the insurance law. He reports his findings of violation to the attorney general (or district attorney), who acts to bring the offender to trial.

[1] In this chapter statements concerning insurance law and administrative practice will be based on New York State, unless otherwise indicated. Complete analysis of the variations between states would be impossible within the confines of a single chapter and of little value to the general student. The term "insurance commissioner," rather than "superintendent," will generally be used to designate the chief state regulatory officer. The only comprehensive study of insurance regulation in the United States is still Edwin W. Patterson's admirable "The Insurance Commissioner in the United States." Two other highly useful sources of information on insurance regulation are Charles C. Center and Richard M. Heins (eds.), "Insurance and Government" and Spencer L. Kimball, "Essays in Insurance Regulation."

[2] New York Insurance Law, Sec. 35.

[3] See pp. 554–555.

What Is "Insurance"?

The state insurance department is often faced with the question whether a given activity is *insurance* and therefore subject to supervision by it. The answer to this question is important because insurers are subject to various special legal requirements and are excused from certain regulations that apply to most other businesses. The statutory definitions, regulations by insurance commissioners, and case law are not consistent or logically satisfying, but in general there must exist a risk of economic loss not under the control of the insurer or the beneficiary under the contract, an insurable interest in that loss by the insured, an assumption of the risk by the insurer, and a plan for distributing that risk among the insured group.[4] Service or warranty contracts have been particularly troublesome. In general a contract by the manufacturer or a servicing agency to perform ordinary maintenance and to replace defective parts is not insurance, but it becomes insurance if the promise protects the owner against fire, collision, or similar perils. For example, a comprehensive guaranty of automobile tires has been considered insurance; a tire warranty promising indemnity against defects in the tire was not.

Another problem is that of the extent to which the issuing of variable-annuity contracts is insurance and to what extent an investment business.

Power of Insurers

The kinds of insurance that an insurer may write are carefully defined in the insurance law. In this respect, insurers are broadly divided into two types, *life* and *property and liability*. Life insurers may write life insurance, annuities, and health insurance. Property insurers may write all other kinds of permissible insurance and health insurance.[5]

Formation of Insurers

In nearly all states insurers may be organized under general statutes. Persons proposing to incorporate an insurer, stock or mutual, must publish their intention, after approval by the commissioner. Following publication, a decla-

[4] For a comprehensive study of legal definitions, see H. S. Denenberg, "The Legal Definition of Insurance."

[5] Title insurance is not included in the powers of property insurers, but is assigned to insurers specializing in that field. The New York law also permits "insurance of life of property" by specializing insurers, but no such insurance has been written.

The earlier compartmentalization of property and liability insurers into fire insurers, marine insurers, and casualty insurers has been described on pp. 272–273.

ration is required to be submitted to the commissioner setting forth the proposed charter of corporation, its plans for operation, and its proposed name, "which shall contain a distinctive word or words, and, in the case of a mutual corporation, shall contain the word 'mutual.' " Its name may not be identical with or so similar to that of any other insurer "as to be likely to deceive or mislead the public."

A stock company must have paid-in capital and surplus sufficient to meet the minimum requirements for engaging in the kinds of insurance that it proposes to write. The smallest amount of capital permitted in New York is $100,000; the largest required for doing all kinds of permitted insurance business (other than life) is $2,200,000. Minimum paid-in surplus shall be 50 per cent or 100 per cent of capital, depending on the kind of business. Well-financed companies have an initial surplus considerably in excess of the minimum requirement. Alternatively, a property insurer authorized to write all property lines (other than title and life-of-property) may be formed with a minimum capital of $500,000 and a minimum surplus of $3,050,000.

A mutual company must have a minimum number of applications for insurance from a minimum number of applicants; other minima are applicable to amount of insurance, number of risks, number of employees (employers' liability and workmen's compensation), and amount of premiums to be paid in. The company is also required to have a minimum paid-in initial surplus, which may be borrowed or advanced on agreement that it shall be repaid "only out of free and divisible surplus . . . with the approval of the superintendent." These minima are dependent on the kinds of insurance to be written.[6]

In New York,[7]

> The superintendent may refuse a license . . . if he finds, after notice and hearing that any of the proposed incorporators or directors of a stock corporation, or that any of the directors of a mutual corporation, has been convicted of any crime involving fraud, dishonesty, or like moral turpitude, or is an untrustworthy person.

Having determined by examination that the insurer has met all requirements for incorporation, and all required deposits[8] having been made, the commissioner may license the corporation to do the kinds of business specified in its charter, but it may do no insurance business without a license.

[6] Appropriate provision is made for the formation of insurers other than stock or mutual, and certain insurers are exempt from such regulation.

[7] Insurance Law, Sec. 48.

[8] See pp. 544–545.

Admission of Insurers

The requirements just explained have to do with *domestic* insurers, i.e., insurers organized and licensed to do business in the state of their domicile. *Foreign* insurers (those domiciled in other states) and *alien* insurers (those domiciled in other countries) may also be licensed to do business in a state.

With some qualifications, the requirements for admission of foreign insurers are that they shall conform, as to their entire operations, to the requirements for the condition and conduct of domestic insurers. They are often also required to make and maintain deposits for the primary protection of their insureds who are citizens of the admitting state.

An alien insurer is required first to set up and maintain a branch office in some state, which is roughly equivalent to a domestic insurer. It must make a deposit in that state and may make remittances to its head office in its country of domicile only on approval of the commissioner. Having established such a branch office, its admission to other states is dependent on its conformity to requirements similar to those for licensing foreign insurers.

Refusal of license to an insurer is always indicated if it cannot meet the standards set up in the statue for admission to do the kind of business for which the license is desired, that is, if the power to do so is not granted under its charter or if it has not the legal minimum capital. Sometimes the commissioner may go further and deny the license if he believes the insurer will not be able to operate safely.

Revocation of license is prescribed for violation of certain statutory requirements and is also in order in cases of evident insolvency. In most states persistent fraud will also justify revocation. In some states, e.g., California, the commissioner may suspend the license for not over 1 year if he ascertains that the insurer is conducting its business fraudulently, is not carrying out its contracts in good faith, or habitually forces the insured to accept less than is due him in order to avoid litigation.[9] There is considerable variation in detail in the several states. In some the commissioner has more discretion than in others, but a resourceful, vigorous commissioner can usually find the power to enforce sound practice and good financial condition.

Solvency of Operating Insurers

Since solvency of operating insurers is the prime purpose of state supervision, the insurance law and the state insurance department are particularly concerned with methods to that end.

[9] Insurance Code, § 704.

Assets. The insurance law governs the investments of insurers—in general, they are required to be of high quality in terms of safety; the insurance commissioner is charged with seeing that the investments conform to the law and that their valuation is accurate. The law provides that investments must be authorized or approved by the directors and that directors shall have no personal interest in the investments or in their sale to the insurer.

Life-insurance companies and fraternal benefit societies, in view of their long-term contracts and the nature of their insureds and beneficiaries, are restricted in their investments to a greater degree than are other insurers. Until recently a life insurer was permitted to invest only in bonds and mortgages and in real estate to the extent that it was necessary for convenient accommodation in the transaction of its business or to protect itself in connection with debts owed to it. They may now invest their general assets to a strictly limited extent in stocks and real estate for revenue; separate-account pension-plan[10] assets are not subject to these restrictions.

The law specifies what assets are *admitted*, i.e., officially recognized in determining the financial condition of an insurer. In general, they are the items that may be counted upon, with little question, to be available at their approved values for the satisfaction of the obligations of the insurer. Assets that are not admitted are those of dubious value or availability, for example, premiums more than 90 days past due less commissions, good will, furniture and fixtures, and the excess of book value of investments over the officially approved value.

Asset values are determined largely by the National Association of Insurance Commissioners (NAIC) Committee on Valuation of Securities, which maintains an office in New York at the expense of the various states. Its function is to determine the value, as of December 31 of each year, of securities held by insurers, which value becomes the recognized amount to be entered as an asset in making their financial reports. If a bond is amortizable, the staff of the office determines that fact, the calculation of value being left to the insurer. In the case of nonamortizable securities, careful analysis is made of reported market price or, where the market is limited or nonexistent, of whatever information can be secured. An insurance department is not bound to use the values arrived at by the committee and may be required by law to determine value in other ways, but the committee's values are generally adopted.

Liabilities. Insurers have many kinds of liabilities the amounts of which are not difficult of determination, such as taxes, bills outstanding, losses agreed upon but unpaid, and dividends declared but unpaid. But their principal

[10] See p. 363.

liabilities are peculiar to the insurance business, reserves for future losses, for loss-adjustment expenses, and for unearned premiums.[11]

The calculation of reserves is largely a matter of applying formulas incorporated in statutes or set up by insurance commissioners. To the extent that reliable formulas are available, valuation of liabilities is a matter of checking to ascertain whether they have been properly applied. But some reserves are based wholly on judgment, and judgment may enter into the determination of others. Here the aim of the insurance commissioner is to see that the judgment applied is directed to accuracy and that it is sound. Insurers may desire to undervalue reserves in order to make a better financial showing than would be presented if they were accurate, but undervaluation distorts the statement from its purpose of revealing the financial condition of the insurer and may lead to the insurer's having insufficient resources to meet its obligations. Overvaluation, while it is on the side of maintaining solvency, is also a distortion, and by exaggerating expected losses may be used to justify excessive rates or to conceal surplus.

The commissioner must test formulas and judgment by observing trends and by comparing actual disbursements with estimates.

Security Valuation Reserves. The National Association of Insurance Commissioners has, by resolution, approved a *mandatory security valuation reserve* for life-insurance companies and fraternal benefit societies. Requirement of the reserve is made by the insurance commissioner; it is mandatory as an administrative rather than a statutory requirement. The purpose of this reserve is to take account of possible loss through reduction in the value of securities below those used in determining the value of the assets of insurers. Its amount is based in part on the reliability of those values as indicated by analysis of the securities to which they apply.

Limitation of Risk. With some qualifications and exceptions, an insurer may not expose itself to loss on any one exposure in an amount exceeding 10 per cent of its surplus to policyholders. In determining such exposure, recognized reinsurance is deducted, so that the limitation applies to the net amount that the insurer might lose.

Deposits. In many states domestic insurers are required to deposit with the states securities (normally government bonds) related in value to their capital or to the kinds of insurance that they write. Foreign or alien insurers may be required to make deposits as a condition of admission to do business in a

[11] See Chapter 28.

state, and an alien insurer is always required to maintain *deposit capital* in the state in which its branch office is domiciled. In some cases deposits are available initially only for the protection of insureds in the state of deposit.

Deposits for special purposes other than the liquidation of incurred but deferred liabilities tend to defeat the primary purpose of insurance, collecting through premiums a fund to meet losses wherever they occur. Deposit requirements, particularly of states other than that of domicile, are an annoyance to insurers for several reasons. Scattering of assets over the country out of their immediate control requires special records to keep track of them and see that interest is collected and properly remitted. If an insurer desires to dispose of a deposited security, it must arrange a substitution, at best an annoyance and perhaps a cause of loss because of inability to make prompt delivery. There is also a chance of loss in transmittal. On examination of the insurer, certificates must be secured from the custodians to exhibit to the examiners who cannot include them in their physical inspection of securities in the insurer's safe-deposit box. Most state treasurers are bonded, but the bond may not be adequate to cover all funds and securities in their custody, so that there is a chance of loss from that source. Even when the law allows the alternative of a surety bond, some insurers deposit securities rather than incur the premium cost.

The deposit may be in negotiable securities which the state authority is authorized to sell if the insurer fails to meet the obligations to secure which they are deposited, or they may be registered in the name of the commissioner as trustee. They remain the property of the insurer, which is entitled to receive the income on them. Usually, where the law requires a deposit by an insurer for any purpose, the deposit passes through the insurance department for check before going to the state treasurer. Sometimes, but not usually, the insurance commissioner is the custodian.

Dividends. The payment of dividends to stockholders or insured is regulated in various ways, with the basic purpose of preventing payments that would unduly impair the financial condition of the insurer. Such regulation is accomplished by setting limits beyond which dividends may not be declared or by requiring approval of dividends by the commissioner. All states require that life-insurance dividends to insureds be equitable, but most jurisdictions do not impose any such requirement with respect to property-and-liability-insurance dividends or health-insurance dividends. To some observers this position is inconsistent with the strict regulation of property-and-liability-insurance rates described later in this chapter, but the majority position is that the payment of dividends is a prerogative of management.[12] In the case of participating life

[12] For an analysis and support of the minority position, see A. R. Whitaker, "The Regulation of Ex-Post Insurance Rates."

insurers a purpose of regulation is to require equitable annual distribution to insureds of all surplus earnings not subject to other priorities and not required for keeping the insurer in sound financial condition. The accumulation of surplus by such insurers is limited by statute.[13]

The Annual Statement. The primary tool available to the insurance commissioner to keep informed on the financial condition and operations of insurers under his jurisdiction is the annual statement of transactions and their results for the calendar year, and of the insurer's financial condition as of December 31. This annual statement is made in the form and detail required by the uniform blanks prepared by the Committee on Blanks of the National Association of Insurance Commissioners, supplemented by such special reports as the individual commissioner may require, either annually, at shorter intervals, or on specific occasions. Blanks are in two principal forms, one for life insurers, and one for property and liability insurers.[14] They are audited by the state insurance department and, after any necessary corrections, become a part of the records of the department.

The purpose of the annual statement and other reports is to give the commissioner such information as will enable him to determine whether an insurer is conforming to law and whether its condition justifies confidence or requires remedial attention.

The annual statement analyzes assets and liabilities by kind, income by source, and disbursements by purpose. Exhibits of profit and loss and of changes in capital and surplus by source are included. Other exhibits support and analyze certain items of the main statement, where the reasons for them are essential to an understanding of the insurer's condition or operations. A recent supplement to the statement is the *Insurance Expense Exhibit* (fire and casualty), showing in great detail the allocation of expenses in accordance with rules laid down by the insurance commissioners.

Examinations. The commissioner is authorized to examine (audit) any insurer licensed to do business in his state whenever he considers it expedient in the interest of the public. He is required to examine each domestic insurer at least once every 3 or 5 years, depending on the type of insurer. Expenses of examination are borne by the insurer examined. These examinations are very

[13] For a comprehensive study of the payment of dividends to insureds by stock life insurers who also have obligations to their stockholders, see J. M. Belth, "Participating Life Insurance Sold By Stock Companies."

[14] There are several additional forms for special types of insurer.

searching, including verification of accounts, possession of securities, appraisal of property, and methods of operation.

Reports of examinations are made to the commissioner by his examiners, with recommendations where they seem to be called for. The insurer has an opportunity to raise objections to any part of a report. The commissioner, after considering the report and the objections, makes the report, in its original or amended form, a matter of public record.

If every commissioner were to examine all insurers authorized to do business in his state, the trouble and expense to insurers would be intolerable, and the staff required would be tremendous. Accordingly, a system of zone examinations has been worked out through the National Association of Insurance Commissioners, under which each insurer, while regularly examined by its home state, may be concurrently examined by representatives of other states. Arrangements for participation are made by assignment, under the rules of the association, of not more than one examiner from each of the five zones other than that of the home state. Assignment of an examiner is not obligatory, and is made only where it seems desirable to the states in the zone.

Handling of Insolvencies

Unfortunately the insurance commissioner cannot prevent all insolvencies. He should be able to detect insolvencies as soon as they occur and be provided with powers to deal with the situation.

Impairment. The capital of a stock insurer is said to be *impaired* when its admitted assets are less than the sum of its liabilities and its authorized capital. A mutual or a reciprocal is impaired when its admitted assets are less than the sum of its liabilities and any required surplus. The insurance commissioner is required to notify any domestic insurer in either of these situations to eliminate the impairment within a period specified in the law and may prohibit the writing of insurance while the impairment exists. In the case of a foreign insurer, its license to do business may be revoked. Similar provisions are applicable to alien insurers.

If the impairment of a domestic stock insurer amounts to 25 per cent of its outstanding capital stock, or its assets do not cover its liabilities and the amount of minimum required capital, and the impairment is not eliminated within a period of not more than 90 days from service of a requisition by the commissioner, it is insolvent and may be taken over by the commissioner for liquidation or rehabilitation. A mutual or reciprocal may be taken over if its surplus is below the minimum required.

Liabilities for these purposes are the amounts required by law or by administrative ruling to be listed as such. They include not only amounts currently due for payment but provision for future obligations under insurance contracts past and present.

Conservation and Rehabilitation. The commissioner may apply direct to a court of competent jurisdiction for an order to take over and conserve a domestic insurer or the assets (within the state) of a foreign insurer[15] when he finds that it is insolvent; that further transaction of business by it would be hazardous to its insureds, to its creditors, or to the public; or that it or its officers are guilty of certain acts or omissions. The order vests in the commissioner title to the insurer's assets and empowers him to carry on its business to whatever extent is, in his judgment, wise.

If the commissioner acts as a conservator, the insurer is permitted to resume title to its property and conduct of its business if, on application of the commissioner or of the insurer, the court is satisfied that grounds for securing the original order either did not exist or have been removed.

The statutes of some states (including New York) make specific provision for rehabilitation, a process akin to reorganization in other fields of business. The grounds on which the commissioner may ask the court for an order directing him to rehabilitate a domestic insurer are similar to those on which he may ask to be appointed a conservator. But rehabilitation is a more drastic cure for the troubles of a delinquent or insolvent insurer. Its purpose is to preserve the intangible assets of the insurer, such as its agency plant, and to put it on its feet again, usually with a slight change in name. In doing this the commissioner is usually able to realize for creditors of the insurer and for insureds a more favorable solution of their difficulties than would result from liquidation and distribution of the remaining assets. On successful completion of rehabilitation, the successor insurer is turned back to private operation. There have been several notable cases of such successful outcome.

Liquidation. If it is not deemed advisable to attempt rehabilitation or if rehabilitation becomes impracticable, a delinquent or insolvent insurer may be liquidated. In New York, the Superintendent of Insurance acts as liquidator, bringing expert knowledge to the task and effecting liquidation much more economically than would be the case if the insurer were to go through the usual receivership proceedings. The commissioner acts as liquidator in several states. About one-third have adopted the Uniform Insurers Liquidation

[15] In many states conservation applies only to foreign insurers.

Act, which promotes uniformity in the processing of claims when the insurer operated in more than one state.

In life insurance, where insureds may be adversely affected by discontinuance of their contracts to a much greater extent than in most other lines, special efforts are made to make favorable reinsurance agreements. A reinsurer would find it necessary to restrict coverage to something less than that provided by the contract with the original insurer but the insured who had become an unacceptable risk would still have coverage, and other insureds would avoid the extra cost of initiating a new contract.

Security Funds. A few states have set up security funds, the purpose of which is to fulfill the obligations of insolvent insurers to pay claims to the extent that their resources fall short.

Six states[16] have such funds to pay claims under workmen's-compensation-insurance contracts. In each of these states, except Minnesota, funds are maintained by assessments on insurers, assessments being suspended when the amount of the fund reaches a specified maximum and resumed if it falls below the maximum. In Minnesota, insurers are required to contribute only when the insolvency of a compensation insurer makes it necessary.

In New York the *Life Insurance Guaranty Corporation* is empowered

> . . . with the approval of the superintendent to assume, reinsure or guarantee or cause to be assumed, reinsured or guaranteed partially or wholly, any or all of the policies or contracts of any member domestic life insurance company and to make available . . . such sum or sums as may be necessary for such purposes.[17]

Newly formed domestic insurers are not eligible until they have transacted business for at least six years. The fund for carrying out these purposes is to be provided by assessments levied on member insurers in the amount necessary "to enable the corporation to meet its immediate obligations and liabilities," but is not to exceed $25 million.

One proposal that has emerged from the hearings of the United States Senate Subcommittee on Antitrust and Monopoly calls for a federal motor-vehicle-insurance-guaranty corporation. The proposal was inspired by numerous insolvencies among insurers specializing in substandard automobile insurance. Most insurers opposed this proposal on the grounds that (1) the guaranty would encourage unsound operations, (2) well-managed insurers

[16] Minnesota, New Jersey, New York, North Carolina, Pennsylvania, and Wisconsin.

[17] New York Insurance Law, Sec. 224.

would be forced to pay costs generated by careless insurers, (3) the plan might impose undesirable controls upon its members, and (4) the plan is a door-opener for more extensive federal regulation. On the other hand, other observers object mainly to its limited scope; they would prefer a plan covering all lines of insurance.

Stockholders' Liability. In the state of Washington stockholders in insurance corporations are individually liable for "all contracts, debts and engagements" of the corporation accruing while they are stockholders to the amount of the par value of their stock, in addition to the amount that they have invested. In other states stockholders are liable to the amount of their interest in the corporation, but are not subject to additional assessment.

Practices of Insurers

Supervision of insurance is concerned not only with insurer solvency but also with the practices of insurers and the competence of insurance personnel. This section deals with the regulation of insurer practices; succeeding sections deal with the competence of agents and brokers, adjusters, and counselors.

Contracts. Insurance contracts are regulated to varying extents, depending upon the nature of the insurance provided by the contract. The details have been discussed in the chapters on contracts. A contract that does not conform to the statute or other applicable regulation is not necessarily invalid; it will be conformed to the legal requirements by interpretation.

Premium Rates. Premium rates for insurance are now generally regulated by the states through their state insurance departments. The purpose of regulation is to enforce the requirement that rates be adequate but not excessive and that they discriminate fairly between risks.[18] The nature of this regulation, however, varies greatly among lines and among states.

In most states most property-and-liability-insurance rates are subject to the model rating law or to a closely related version adopted shortly after the passage of Public Law 15. Under this law insurers must file their intended rates with the insurance commissioner. They cannot use these rates until the commissioner gives his approval or until a waiting period specified in the

[18] See p. 411.

law, such as 10 or 20 days, has expired with no action by the commissioner. The commissioner has the authority to disapprove the rates during the waiting period or at any subsequent time. If the insurer is unhappy about the commissioner's decision, it can appeal to the courts. Rating bureaus are permitted to make filings for members and subscribers, but membership must be optional and provision is made for members and subscribers to request deviations from the bureau rates.

This model law has been subject to increasing attack in recent years. Many insurers claim that they have been denied justified rate increases and been subjected to numerous unnecessary delays. The result, they argue, has been an inadequate supply of insurance as insurers have become more selective, reduced the scale of their operations, or scaled down their plans to expand. Product innovations have also been discouraged because it has often proved difficult to depart from the *status quo*. Competition has been hindered and some states have discriminated against independent insurers and deviating insurers. The critics further claim that this type of regulation places undue political pressure upon the regulators because they are made responsible for approving rate increases. Some regulators, it is claimed, are arbitrary in their decisions. Finally, it is argued, the model rating law has resulted in state insurance departments devoting too much of their limited resources to rate regulation as opposed to examinations and other vital functions.

Those who defend the model rating law argue that competition by itself is not an adequate regulator of property-and-liability insurance prices, that the positive regulation provided by the model rating law is much more likely to produce rates that meet the statutory standards, and that the desired degree of competition can be provided through independent pricing, deviations, and dividends. They observe that once a rate has been approved, it is not likely to be subsequently disapproved; hence the insurer can be more certain of its position. They deny that the actions of most state insurance departments have been arbitrary or politically inspired and plead for more resources in order that they might perform this and other essential functions adequately.

Some of the critics plead for more flexible administration of the existing rating law. Others prefer a California-type law under which insurers need not file their rates, but the commissioner can, through an examination procedure, subsequently disapprove the rates.[19] Another approach would permit insurers to file their rates and use them immediately. Several states have recently converted their laws to the "no-filing" or "file and use" approaches.

At the other extreme there are a few states that have adopted more stringent regulation of property-and-liability-insurance rates. For example,

[19] One feature of the California law which has attracted much less support and less attention is the prohibition of agreements to adhere to the advisory rates promulgated by rating bureaus.

North Carolina requires all insurers writing automobile liability insurance to belong to a single rating bureau and to use bureau rates. Such a requirement is common with respect to workmen's compensation insurance. The state of Massachusetts itself establishes the rates of all insurers writing its compulsory automobile liability insurance. Texas sets rates for fire, automobile, workmen's compensation, and title insurance.

One specific issue in property-and-liability-insurance rate regulation that has attracted considerable attention in recent years as insurance rates have risen is whether the insurer's investment income should be considered in determining whether its rates are reasonable. Those who support such consideration argue that an insurer should be permitted to earn a reasonable return on its stockholders' equity, but that this reasonable return should include its total underwriting and investment income. Part of an insurer's investment income is derived from assets made possible by insureds' premiums; e.g., those corresponding in amount to the unearned-premium reserves, and perhaps to a lesser extent, the loss reserves. The investment income from these "excess" assets is clearly attributable to the insurance business.

Most insurers reject this position for a number of reasons, only a few of which can be cited here. First, if loss reserves, as claimed by some, are funded out of an insurer's capital and surplus, investment income, if considered at all, should be limited to the income or assets equal to the unearned-premium reserve. Second, insureds have no legal or equitable interest in the unearned-premium reserve. Once they pay their premium, the insurer's only obligation is to provide protection. Consequently the insureds are not entitled to any return on the advance payments. Third, if a reasonable profit allowance is established for the entire industry as a per cent of the premium on the basis of the average rate of return on owners' equity, those insurers who maintain a low capital and surplus relative to their premium writings would be permitted to earn larger profits on their equity. Solvency considerations, however, favor a high capital and surplus relative to premiums. Fourth, if capital gains are not to be included in computing investment income (and including them would create an unstable situation), the net investment income on the "excess" assets made possible by the insurance activities of the insurer would amount to much less than 1 per cent of the insureds' premiums. The true income is even less than most computations based on an average rate of return would suggest because the "excess" assets tend to be invested in lower-yielding safer investments.

A few states have recently started to pay some attention to net investment income from the "excess" assets, but in at least two instances these assets have been interpreted to include only those associated with the unearned-premium reserve.

Life-insurance rates are not subject to nearly the same degree of regulation.

They are not filed for approval or disapproval but are subject to statutes forbidding unfair discrimination. Policy-reserve requirements provide some protection against inadequate rates. Group-insurance premiums are, in addition, subject to certain minimum levels in a few states. Because of the absence of rating bureaus in life insurance, there has been much less concern about excessive rates in this field. Blue Cross and Blue Shield rates are regulated closely in many states, but because of the heterogeneity of products and prices, most states rely upon competition to regulate commercial-health-insurance rates.

Cancellations. Most types of insurance contracts give insurers the right to cancel the contract without giving any reason for their action. In recent years there has been considerable public pressure to limit insurers' cancellation rights, particularly in automobile insurance and health insurance. Many states have recently enacted legislation, often supported by insurer associations, that limit the right of insurers to cancel automobile-insurance contracts to certain reasons, such as nonpayment of premiums, suspension or revocation of a driver's license, fraudulent misrepresentation when obtaining the insurance, and conviction of certain crimes. Some states also require 30-day notice of intention not to renew the automobile-insurance policy. A smaller number of states have taken similar actions with respect to health insurance.

Expenses. Provision in the premium for expenses of management is regulated as a part of rate regulation, but there is also regulation of expenses as such. In life insurance, over-all expenses and expenses for acquisition of business are regulated by statute. The object is to prevent extravagance in selling life insurance and in the administration of the life-insurance business, which would be reflected in the cost of insurance to insureds. Over-all expenses of certain mutual property insurers are also limited by statute.

Since regulation of rates and of expenses requires accurate and comparable records of expenses, the commissioner is authorized to prescribe uniform classification of accounts. Investigations have demonstrated that, without regulation, insurers pursue diverse practices in allocating expenses, resulting in inaccuracy and incomparability of expenses incurred by insurers.

Rebating. Insurers, their representatives, or brokers may not offer or give, nor may insureds accept, any consideration for placing insurance, whether in the form of cash or other advantage. Such a consideration is a *rebate* and illegal.

Advertising. The content of any insurer's advertising purporting to make known its financial condition must conform to the requirements of the insurance law. The law requires that such advertisements shall contain certain specified items, and that the figures shall correspond to the last official statement filed with the insurance commissioner. The majority of the states have adopted the NAIC health-insurance advertising rules.

Unfair Trade Practices. The NAIC has adopted and recommended a model unfair-trade-practices act which has been enacted, in substance, in all 50 states.

Complaints. Every insurance department is organized to receive and act upon complaints, most of which are received from insureds who believe themselves aggrieved by an act or omission of an insurer, usually through failure to settle a loss in accordance with the insured's claim. The insurance commissioner takes appropriate action if he finds that a law or regulation has been violated. If he feels that the insured has not been treated properly, though legally, he may try to induce the insurer to satisfy the insured, in whole or in part.

Agents and Brokers

An agent or broker, in order to act as such, must be licensed by the state in which he does business. As a prerequisite to the issuance of a license, the commissioner must satisfy himself that the applicant is competent and trustworthy. The provisions for ascertaining these qualities vary greatly, some states having strict laws and examinations and a few having very mild requirements. The tendency is toward strict requirements for qualification, including written examinations. Examinations and other requirements for agents are less strict than for brokers, since the insurer for which an agent is to act certifies him to the commissioner and is broadly responsible for his conduct,[20] while a broker is a free lance and offers himself as a representative of the insured.

All states license agents, but a few make no provision for licensing brokers. Certain of these latter do license nonresident agents or brokers.

Severe penalties are provided for acting as an agent or broker without a license. The fines are substantial, and there is frequently an alternative of imprisonment at the option of the court. Usually a single offense is sufficient

[20] See p. 396.

to invoke the penalty. In brief, the law makes it unprofitable to act as an insurance agent or broker without a license. The penalty for representing or placing business with an unauthorized insurer is as severe as for operating without a license.[21] These penal provisions reaching to the individuals give force to insurance regulatory laws and effective power to commissioners.

The power to compel obedience to regulation rests also in authority for the refusal, or revocation, of licenses. The right to exercise it is usually sufficient to prevent the need. In some states the commissioner may refuse or revoke "for good cause shown," though his action is subject to court review. In such cases, if it is shown that the commissioner has exercised a reasonable discretion for the protection of the public, the courts will usually not interfere.

The law provides that a license is not to be granted if the purpose of the applicant is mainly to obtain the commission on policies issued to cover his own risks, risks he controls, or the risks of corporations of which the firm is an affiliate or subsidiary. This would be tantamount to a rebate or preferential rate. Revocation is ordinarily possible only for essentially fraudulent transactions, embezzlement of premiums from either the insured or the insurer, misrepresentation of policies, or inducement by misrepresentation to drop one policy in order to take out another with a different insurer, a transaction, known as "twisting," that is more frequent in life insurance than in any other branch where it almost always results in loss to the insured.

Practically every state requires that insurance contracts other than life or risks located within the state must be countersigned by a resident agent of the insurer, and many require that the resident agent retain a specified part of the commission, often 50 per cent, when the insurance is negotiated by a nonresident agent or broker.

Adjusters

About half the states have licensing laws applicable to adjusters representing insurers. All these laws apply to independent adjusters, most of them to bureau adjusters, and some to staff adjusters. A few laws require agents who adjust losses to be licensed for this purpose. Written examinations are required in about half the laws.

A larger number of states require that public adjusters be licensed. Prerequisites of licensing are examinations and filing of information to determine their competence and trustworthiness.

[21] There are provisions under which a broker who has complied with certain requirements may place with unauthorized insurers insurance that he is unable to place with those authorized.

Counselors

Insurance counselors offer advice to insureds or prospective insureds concerning their insurance programs in return for a fee. Such counselors are required, in a few states, to be licensed, but only in respect of life insurance or annuities. In some of these states, passing a written examination is a prerequisite to a license. Maryland and Massachusetts require licenses and passing of a written examination to qualify as counselor in respect of insurance in general. New York requires counselors to register.

Anticoercion Laws

Over half the states have anticoercion laws. New York prohibits a lender from making the negotiation of an insurance contract through any particular agent or broker a prerequisite to financing the purchase of property or to loaning money on the security of a mortgage. A recent extension of the law prohibits the beneficiary of any insurance required by statute from requiring that the insurance be obtained from a particular agent, broker, or domestic insurer.[22]

Extraterritorial Regulation

In general, the laws of each state govern all operations of insurers organized under them. However, the New York law places limitations on acquisition expenses of all life-insurance companies licensed to do business in that state. These limitations must be observed as to all the business of such companies, not merely as to their New York business. So also, if the law of any state requires of a domestic mutual insurer that its policy carry a provision relating to the liability of insureds to assessment, all the policies of the insurer, wherever issued, must carry that provision.

The effect of the application of the state law, on the one hand to the operations within its borders of foreign as well as domestic insurers, and on the other to all operations of domestic insurers, gives great scope to the laws of states having many insureds with large exposures attracting foreign insurers to operate there and also having many domestic insurers doing business over a wide territory. To a considerable extent the entire operations of a foreign insurer must conform to the standards of a state to which it is admitted. A strong insurance department administering a strict insurance law has a beneficial effect on insureds' interests far beyond its borders and sets an example

[22] Penal Law, Secs. 442(a), (b), and (c).

for other states. To the extent that it reaches into states having weak laws or poor administration it tends to overcome these weaknesses.

Service-of-process Laws

Insureds and beneficiaries under insurance contracts effected by mail with an insurer unauthorized to conduct business in the state were long under the disadvantage of being unable to take action against such insurers except in their state of domicile. Nearly all states now have laws under which the transaction of business in the state (what constitutes transaction of business is defined in the law) operates to appoint the commissioner as the attorney of the unauthorized insurer to accept service of process in a proceeding arising out of the contract of insurance. The authorized insurer is then subject to the jurisdiction of the state's courts. The constitutionality of such laws has been upheld by the Supreme Court of the United States.

Reciprocal and Retaliatory Laws

Some states have *reciprocal* laws. Such a law in state A provides that it will grant the same privileges to insurers or producers (agents, brokers, or salaried salesmen) of any other state as are granted to the insurers or producers of state A doing business in that other state. Or it may provide that state A will regulate its domestic insurers or producers in their relations with the other state according to a specified standard if the other state regulates its domestic insurers according to the same standard.

A *retaliatory* law in state A provides for imposing the same requirements on insurers or producers of another state doing business in state A that the other state imposes on the insurers or producers of state A. If, for example, the other state taxes its own insurers 2 per cent of their premiums but taxes those of other states 4 per cent, then in state A insurers of the other state would be taxed 2 per cent more than domestic insurers. Reciprocal or retaliatory laws are found in the statutes of nearly all states. They constitute a weapon of defense against unfair discrimination but may be, and have been, invoked by weak commissioners to protect their friends against proper regulation.

Such laws may have an effect not contemplated when they were proposed. In the legislature of a Western state a bill was introduced to provide for retirement pensions for firemen by a tax on fire-insurance premiums. Presumably to forestall the opposition of local insurers, it was provided that they would be exempt from the proposed tax. If the bill had passed, the burden on them of additional tax in other states under retaliatory provisions would have been

several times the proposed local tax. The local insurers led the fight against the bill, which was defeated.

Such laws are not held to be unfair discrimination against insurers in interstate commerce.

Informational and Advisory Activities

A principal function of insurance departments is furnishing information on insurance matters to the public, other state departments, and the legislature. It suggests legislation and gives opinions on bills that are introduced. In an informal way it gives advice on insurance activities being considered by insurers or producers.

The department makes an annual report consisting of a record of its activities, relation of important insurance events, data on insurance operations and the condition of insurers authorized to do business in the state, and often the condensed annual statements of such insurers.

It issues press releases on current insurance events. It answers specific inquiries for insurance information. In general, it serves as the official state agency for facts and opinions on insurance matters.

TAXATION OF INSURERS

No discussion of governmental supervision of insurance would be complete without some brief description of the taxes paid by insurers. Reference has already been made to state premium taxes which are the principal taxes imposed by the states. These taxes, which may vary among insurers (e.g., domestic versus nondomestic or stock versus mutual), are usually around 2 per cent, the maximum rate in any state being 4 per cent.

The major tax levied on insurers by the federal government is the income tax. Stock property and liability insurers pay regular corporate income taxes on their investment income plus their underwriting gains. Mutual property and liability insurers whose gross premiums plus their investment income exceed $500,000 are taxed on the same basis as stock insurers, but they may deduct from their taxable income dividends paid to policyholders and appropriations to a special "protection against loss" account which is to be used in years when underwriting losses exceed investment income. Small mutuals whose gross premiums plus their investment income is less than $150,000 are not taxed. If its gross premiums plus investment income exceeds $150,000 but is less than $500,000, a mutual insurer can elect to be taxed in the same manner as larger insurers or solely on its investment income. However, a mutual in this size category cannot change the taxing method to its advantage from year to year.

Life insurers pay regular corporate income tax rates on taxable income composed of three parts: (1) investment income less investment expenses and interest required to maintain policy reserves adjusted in a manner prescribed in the law, (2) one-half of the excess of the gain from operations[23] over the taxable investment income in part (1) less certain deductions, including dividends to policyholders, and (3) stockholders' dividends paid out of an account established with income not taxed in the second part. Net capital gains are taxed at capital gain rates.

QUESTIONS

1 If a domestic insurer is licensed and seeks business, to what extent may a prospective insured rely on its capacity to meet its obligations?
2 An insurer advertises its financial condition by presenting a condensed financial statement. What reasons would an insured have to credit the accuracy of the figures in the statement?
3 What differences are there between the financial condition of an insurer that becomes insolvent and that of a mercantile corporation? What is the significance of these differences?
4 A workman is awarded compensation and the award is not contested. The employer is insured in the ABC Indemnity Co. What sources of payment may the workman look to in the event of insolvency of the insurer and consequent inability to pay the award in full?
5 An insured who has made a claim against an insurer feels that the insurer is attempting to avoid full payment by unwarranted tactics of delay and offers of a fraction of the value of the claim. What assistance is available to the insured from his state insurance department?
6 Why should a broker, who is chosen by the insured to represent him, be obliged to meet strict requirements for license to do an insurance business? Why should an agent, for whose actions an insurer is responsible, be required to meet similar requirements?
7 What is the proper approach to rate regulation?
8 In what ways do insurance commissioners regulate the practices of insurers?
9 Comment on the assertion that insurers receive more favorable treatment under federal income tax laws than do manufacturing corporations.

[23] See p. 452.

36
THE SOCIAL-SECURITY SYSTEM: FUNDAMENTALS

Government regulation of private insurers is only one of the ways in which the government concerns itself with the treatment of pure risks faced by its citizens. Indeed, the government plays a much more active role through the social-security system.

The term "social-security system" has been defined in several ways. For example, one broad definition would include all private and public programs dealing with all threats to the security of a nation's citizens, *security* being defined as "the quality of being protected against or safe from dangers and threats of diverse kinds."[1] The security of a nation's citizens has many dimensions. It involves, among other things, their economic security, political security, physical security, and emotional security. It is impossible to treat the social-security system defined this broadly in several volumes, let alone two chapters in a basic text on insurance. It is also true that most people do not interpret the term "social-security system" this broadly. Consequently this text will adopt a more manageable definition that would also be acceptable to more persons.

First, the system will be confined to those programs dealing primarily with the economic insecurities associated with the perils of death, old age, unemployment, and poor health. Programs dealing with speculative risks will not be considered part of the system nor will programs dealing with such perils as fire, automobile accidents, and flood. The decision to exclude such programs as the government flood-insurance program and proposed automobile compensation plans is debatable, but most social-security experts do not consider such plans to be part of the social-security system. In the future this position may change. Although these two programs are not discussed as part of the social-security system, because of their importance they are discussed in Chapters 38 and 39, respectively. Death, old age, unemployment,

[1] J. G. Turnbull, C. A. Williams, Jr., and E. F. Cheit, "Economic and Social Security," p. 4. Much of the current chapter is based on chap. 1 in this text.

and poor health have been emphasized because everyone faces important economic losses from these perils, regardless of his economic position.

Second, the system will be confined to programs administered or required and closely supervised by the government. Private life and health insurance, for example, will not be considered part of the system despite the fact that this insurance clearly has social implications. This decision would be acceptable to most persons because they do not regard private insurance (except, as will be indicated later, workmen's compensation insurance and some group temporary disability insurance) to be a social-security program.[2] Private insurance, of course, is discussed elsewhere in this text in considerable detail.

Third, the system includes both preventive and alleviative programs. Preventive programs include steps taken before any losses to reduce their likelihood of occurring and their potential severity, plus steps taken after the loss to reduce the loss severity. Illustrative public preventive programs include safety codes, police protection, rehabilitation activities, fiscal measures designed to stimulate employment, and the "war on poverty." Alleviative programs, on the other hand, reduce the undesirable economic consequences of the losses that do occur. Despite the critical importance of preventive programs, space considerations limit the discussion here to alleviative programs. This decision, like the earlier one, is in accordance with the common definition of a social-security system. A general treatment of private and public preventive programs has already been presented in Chapter 7.

In summary, for the purpose of this text the social-security system will include all alleviative programs administered or required and closely supervised by the government dealing with the perils of death, old age, unemployment, and poor health. Because only the United States social-security system will be considered, the reader should realize that many of the features of the United States system are unique.

This chapter will describe the basic types of alleviative programs and their most important characteristics, whether social insurance is "insurance," the reasons for the development of the present extensive system, the decisions that must be made concerning program characteristics, a summary view of the present system, and two recent proposed additions to that system. The next chapter will describe the characteristics of the most important social-insurance and public-assistance programs.

TYPES OF ALLEVIATIVE PROGRAMS

The alleviative programs under the social-security system can be divided into two principal categories: (1) public assistance and (2) social-insurance and related programs.

[2] For a counter-position emphasizing the interrelationships among private and public programs, see Turnbull, Williams, and Cheit, *op. cit.*

The principal characteristics of public assistance are that the recipients must demonstrate that they are needy and that the amount of the benefit depends upon the extent of the demonstrated need. Under social-insurance and related programs, on the other hand, benefits are paid to all beneficiaries who satisfy certain eligibility requirements, such as employment in a covered occupation for at least a specified number of calendar quarters. Beneficiaries need not demonstrate their individual need. Benefits may be based upon the presumed average needs of the various types of beneficiaries, but the actual need in a particular case may exceed or be less than the benefit. Because of these principal characteristics, considerably more discretion is involved in the administration of most public-assistance programs than in the operation of most social-insurance programs.

Other major differences between public assistance and social insurance are that (1) public-assistance plans are usually financed by general revenues, which in turn are derived from some progressive tax system, while social-insurance programs are usually financed by earmarked taxes derived from a less progressive, if not regressive, tax structure; (2) public-assistance benefits are supported by federal, state, and local funds, whereas social-insurance benefits are financed by federal and state funds and private premiums or contributions; (3) public-assistance programs are administered directly by the state or local government, the most important social-insurance programs being administered in whole or in part by the federal government; (4) only recipients are directly concerned with public-assistance plans, but all covered persons, including beneficiaries and the much more numerous potential beneficiaries, have a direct stake in a social-insurance program; and (5) some persons who are eligible for public assistance fail to claim their benefits because of pride or a distaste for the needs test, but few eligible persons fail to claim their social-insurance benefits, which are made available as a "matter of right."

The United States social-security system includes both approaches. Social-insurance and related programs dominate the system largely because most persons strongly prefer to receive definite benefits without being required to demonstrate their individual need. For various reasons, however, many persons are not eligible for social-insurance benefits or receive benefits that are less than their needs. These people may have to rely upon public assistance. Present social-insurance and related programs also are limited to certain causes of loss, such as death, long-term disability, and short-term unemployment. The problem of long-term unemployment, for example, is handled by other programs, including public assistance. The primary case for public assistance is that funds are directed toward the families who need them most.

The distinction between social-insurance and related programs is much more arbitrary. All of these programs make benefits available upon the occurrence of certain contingencies without requiring the demonstration of

individual need. Some authorities are willing for this reason to call this entire group of programs "social insurance." After carefully considering several alternatives, the Committee on Social Insurance Terminology of the American Risk and Insurance Association has developed a more restrictive definition for this term. No distinctive label has been coined for related programs. According to this definition, a "social-insurance" program possesses the following distinguishing characteristics: (1) Persons eligible for coverage must be covered, except in unusual cases; (2) eligibility for benefits is conditioned upon contributions having been made to the program in behalf of the claimant or the person to whom the claimant is a dependent; (3) the method for determining benefits is prescribed by law; (4) the benefit structure should, except in unusual cases, stress social adequacy rather than private equity—in other words, the program should redistribute income to achieve social objectives such as favoring low-income workers or persons with many dependents; (5) there should be a definite long-range plan for financing benefits; (6) the cost of the program should be borne primarily by earmarked contributions; (7) although private insurers may be involved in daily operations, the plan should be administered or closely supervised by the government; and (8) the program should not be limited to the government's own present or former employees. Illustrative of the related programs excluded by this definition are the Civil Service Retirement System, because the federal government established this program solely for its own employees, and veterans' benefit programs, because they are financed out of general revenues and were established for former "employees." Some veterans' benefit programs are not even related programs because the claimant must demonstrate that his income falls below a specified level. Some of these conditions may have to be relaxed as the social-security system develops new approaches to new and old problems, but for the purposes of this text this definition will be adopted.

IS SOCIAL INSURANCE "INSURANCE"?

One question that has generated considerable heat for many years is whether social insurance is "insurance." Many observers believe that the answer is clearly "no" with respect to many social-insurance programs. They point to the emphasis upon social adequacy, the absence of a legal contract, and the method of financing, which often defers many of the costs to future generations. They believe that the benefits are better described as transfer payments from one sector of the population to another. They believe that public acceptance of social-insurance programs is often influenced by the "halo effect" of the insurance label and that unfair comparisons are often drawn

between the relative performance and efficiency of social insurance and of private insurance.

The answer to the question depends upon how one defines insurance. If an insurance program must possess all of the characteristics typical of private insurance, social insurance is not insurance, as will be demonstrated below. On the other hand, social insurance is a device for pooling and sharing the risks of death, old age, unemployment, and poor health. Consequently it possesses the only necessary conditions for insurance specified in the definition on p. 62.

Private insurance differs from social insurance, however, in several important respects. (1) Each individual decides how much, if any, private insurance he wants to purchase. Employees, it is true, may have no choice under employee-benefit plans, but the decision is made voluntarily by someone other than the insurer; e.g., their employer or union. (2) Benefits and premium rates are prescribed by a contract which cannot be changed except by mutual consent. (3) The benefits are related on an actuarial basis to the contributions paid; i.e., private equity is an important goal of private-insurance pricing. (4) Numerous insurers compete with one another for business. Social-insurance programs are compulsory for most people; benefits and contribution rates are not prescribed by law but are subject to change; social adequacy is usually stressed; and, although numerous private insurers may be involved, the program is often administered by a single government insurer.

Certain characteristics of social insurance enable it to encompass some risks, such as unemployment, that private insurers have been reluctant to write. The compulsory feature avoids the adverse-selection problem mentioned on p. 461; the flexibility in benefits and contribution rates plus the compulsory feature enables the program to be adapted to changing conditions.

DECISIONS ON PROGRAM CHARACTERISTICS

In designing a social-security program, numerous questions must be answered. The answers depend upon the weights one assigns to a variety of objectives: (1) the achievement of basic economic security for the nation's citizens, (2) the protection of personal liberties and the development of individual incentives and responsibilities, (3) the encouragement of private institutions such as private insurance, (4) honest, efficient, and economical administration of the program, (5) the preservation of states' rights, and (6) desirable economic by-products, such as an improved allocation of industry and the reduction of "fiscal drags" upon the economy, particularly during periods of recession. In practice, of course, one cannot deny that immediate political pressures have exerted considerable influence.

The most important questions, with some illustrative sub-questions, are the following:

What Perils Should Be Included?

Is the peril universal? Does it cause serious problems? Would its inclusion pose any moral or incentive problems? Are its existence and continuance easy to detect? How should the peril be defined for the purpose of this program?

Who Should Be Covered under the Program?

Should eligibility be limited to employed people? If so, what employments should be included? Should employees of small employers be covered? Are there any age requirements? Who "needs" the coverage? What administrative problems exist? Are there any constitutional issues involved?

What Eligibility Requirements Should Be Established for the Initial and Continuing Receipt of Benefits?

Should there be a certain minimum period of coverage or amount of contributions? Should there be any age, remarriage, or dependency requirements? Must the person be actively seeking work, attending school, or engaged in some other activity? If need is a factor, how is it defined?

What Benefits Should Be Paid, and in What Form?

What should be the general benefit level? Should the objective for the average recipient be a subsistence level of income, a "modest but adequate" level, or some level that makes private preparation unnecessary except to provide luxuries? Should the benefit structure favor some groups, such as those with low incomes and many dependents, over others? If so, how far should this redistribution of income be carried? What minimum benefits, if any, should be provided? What maximum benefit? Should the benefits be paid in cash, thus providing freedom of economic choice, or should the system provide service benefits in order to increase program controls over the use of the benefits and over the cost and quality of the services rendered? If service benefits are adopted, should the government purchase these services or provide them direct?

How Should the Program Be Financed?

How should the costs be distributed among the present generation of taxpayers? How should the costs be distributed among past, present, and future generations of taxpayers? Should reserves be established, or should the

program operate on a pay-as-you-go basis? What levels of government should collect the taxes? Should the program be financed out of earmarked contributions, private-insurance premiums, or general revenues?

Who Should Administer the Program?

What should be the mix between private and public administration? What levels of government should be involved? Should one level of government set general policies, with daily administration left in the hands of lower levels of government or private insurers? If private insurers are eligible to underwrite the program, should they be forced to compete with a competitive state fund? On what terms?

These questions are sufficient to indicate the complex issues that must be resolved in designing a social-security system. In the United States a pluralistic complex system has developed because these questions have been answered in many different ways. In large part these different answers have been occasioned by the fact that (1) this nation's economic security system has evolved over a long period of time on a patchwork basis and (2) the six objectives stated at the beginning of this section have forced many compromise solutions.

BACKGROUND OF DEVELOPMENT OF THE PRESENT SYSTEM

In an affluent nation devoted to rugged individualism and the conquering of new frontiers during most of its existence, it may be surprising to find such an extensive social-security system. At present 82 per cent of the aged are receiving income benefits under Old-Age, Survivors, Disability, and Health Insurance, the nation's most extensive program. Total benefits paid under that system in 1967 amounted to $26.0 billion; contributions toward the system totaled $29.2 billion. Social welfare expenditures of all sorts in fiscal year 1966–1967, composed mainly of expenditures under the social-security system and for education amounted to 13.1 per cent (4.7 per cent for education) of the $763 billion gross national product in that fiscal year.

A variety of reasons has led to the adoption of the present system. Broadly it may be said that, with respect to each part of the system, a need for security of some sort was felt and that governmental action seemed desirable or necessary to meet the end. Just as elsewhere in the governmental sphere, the determinants of the action and of the form of the action have been a complex of motives and reasoning, selfish and unbiased, political and logical, shortsighted and statesmanlike. The influences have been economic, political, and social.

Increasing Industrialization and Urbanization

Increasing industrialization and urbanization is probably the major reason for the extensive development of the present system. Some system, however, dates back to the early settlers in Virginia and Massachusetts. With the passing of the feudal system in England, poverty had become a more acute problem and several English Poor Laws in the sixteenth and seventeenth centuries made local authorities responsible for granting relief to the aged poor, apprenticing poor children to employers, and employing able-bodied "paupers." Relatives, however, were made primarily responsible for the poor of all types, and local action varied greatly among communities. In almost all communities the law was tightly administered and beneficiaries were regarded as "second-class citizens" who were largely responsible for their own condition. In 1639 the Massachusetts Bay Colony passed a poor law patterned after the English precedents. During the eighteenth century the poorhouse became the most popular approach to helping needy persons, but by the end of the nineteenth century there was increasing discontent and dissatisfaction with this approach, particularly with the treatment of the needy aged, needy dependent survivors of deceased workers, and the needy disabled.

In a predominantly agricultural nation with an expanding frontier, most citizens accepted the poor law and the poorhouse as an adequate economic-security system. Families had relatively few needs and were largely self-sufficient. Families were large and tied together by common interests and problems. If a member of the family became disabled, aged, widowed, orphaned, or unemployed, he could usually return to his father's home or join some other relative without disrupting too much their living habits or their consumption patterns. Furthermore, he could make himself useful by performing some of the many household chores. With increasing industrialization and urbanization, moving in with relatives became a much less satisfactory solution for several reasons. More people worked for someone else for a money wage, and their ability to remain employed was subject to many uncertainties. Industrial accidents, occasioned by mechanized work, the interdependence of workers under the factory system, long hours, and the absence of safety programs disabled, maimed, and killed an almost unbelievable number of workers. Moreover, as families became less self-sufficient, the loss of the breadwinners' wages became more significant. The fact that these wages were low for most workers prevented them from saving much, if anything, for a "rainy day." It also became much more of a burden to have a needy relative join the family unless he could add cash to the family budget. Relatives became more widely separated geographically, which tended to lessen family ties. A divergence in educational levels and interests among generations, the desire to improve the standard of living of the immediate

family, and the increased cost of raising children were further complicating factors.

Private institutional arrangements for providing outside assistance were gradually developed. Churches, labor unions, fraternal organizations, and charities aided needy persons, but financial limitations placed serious constraints on their activities. Private life insurance expanded rapidly following the Civil War, but most workers could not afford more than token protection or did not appreciate the benefits of insurance. Health insurance was available only on a limited basis and there was no private insurance against unemployment.

The European Experiments in Social Insurance

Toward the end of the nineteenth century several European nations began to experiment with social insurance. The first national system of social insurance for the working classes was created by Germany in the 1880's. Starting with a sickness-insurance law in 1883, workmen's compensation and its insurance were added in 1884, and old-age and invalidity insurance in 1889. Unemployment insurance was not adopted until 1925. Great Britain introduced the principle of workmen's compensation in 1897 and extended its obligation broadly in 1906. Old-age pensions, sickness insurance, and unemployment insurance came later. Finally, under the Labour Government, the comprehensive National Insurance Scheme, the Industrial Injuries Scheme, and the National Heaith Service went into effect in 1948.

Study of social-insurance theory and practice by individuals and by government officials and bureaus in the United States started shortly after European countries began adopting such laws and influenced the development of the present system. In 1891, the United States Bureau of Labor commissioned John Graham Brooks to make a study of the German system. In 1898 a study of social insurance was made at the request of the Massachusetts Legislature by the Bureau of Labor Statistics of that state. State commissions to study workmen's compensation for industrial accidents were appointed in Massachusetts in 1903, in Illinois in 1905, and in Connecticut in 1906. The employers'-liability approach that existed at that time and its defects have already been described on pp. 221–223. A notable step was taken in 1906 in the organization of the American Association for Labor Legislation, which consistently sponsored workmen's compensation laws and drafted several model bills.

The *Twenty-third Annual Report of the Commissioner of Labor* (1908), published in 1909, was a study of "Workmen's Insurance and Benefit Funds in the United States" and brought out their general inadequacy. The following

Twenty-fourth Annual Report, published in 1911, was an extensive study in two volumes of "Workmen's Insurance and Compensation Systems in Europe."

At about the same time the Russell Sage Foundation undertook a survey of the conditions of the working population of Pittsburgh—the "Pittsburgh Survey"—and published its findings in a series of volumes. One of these, "Work Accidents and the Law," by Crystal Eastman, published in 1910, gave great impetus to the movement to substitute workmen's compensation for employers' liability.

Three states appointed commissions to study workmen's compensation in 1909, six in 1910, and nine in 1911. In 1911, as a result of study and agitation, 10 states enacted workmen's compensation laws: New Hampshire, Massachusetts, New Jersey, Ohio, Illinois, Wisconsin, Kansas, Nevada, California and Washington. The order in which they are named emphasizes their wide geographical distribution and the variation in their interests.

Workmen's compensation thus became the first United States social-insurance program. It was not until 1935 that any other social-insurance programs were adopted. Considerable activity did take place before that time on the public-assistance front but with limited success. In 1907 Massachusetts became the first state to study old-age pensions for the needy aged, but its report was negative. Agitation for public aid to needy mothers in order to provide home rather than institutional care for dependent children began as early as 1909, and measures to that end were repeatedly urged in the annual reports of the United States Children's Bureau. In 1911 Missouri and Illinois established "pension" systems for needy widowed mothers.

Beginning in 1915, commissions were appointed in several other states to study old-age pensions, and the model bill of the American Association for Labor Legislation was introduced in 24 legislatures in 1923. It was enacted by three. At about the same time several states appointed commissions to study sickness insurance. Opposition from a variety of sources became so powerful that agitation for such measures was dropped during the decade of the 1920's and attention given to other aspects of the general problem.

A few labor unions had provided unemployment benefits before 1920, but the numbers affected were not large. Also a few employers, notably the Dennison Manufacturing Company, whose industries had been subject to high seasonal fluctuations, had endeavored to stabilize employment and had established unemployment-benefit schemes The minor depression of the early 1920's gave some further impetus to this movement.

By the early 1930's, seven states had passed old-age assistance laws, but two of these laws had been declared unconsitutional. More than half the states provided cash benefits for needy widowed mothers, but the benefits were small. Limited assistance for the needy unemployed was provided through poorhouses or through "outdoor" or "work" relief.

Why Social Insurance Developed More Slowly in the United States. The lag between European programs and between workmen's compensation and the Social Security Act of 1935 has been explained in several ways. First, the inspirations behind the German and English precedents did not apply in the United States.[3] Germany legitimized her system by stressing the duty of the state to protect the individual for reasons of national and public interest. The program was viewed by Bismarck, its creator, as a means of protecting the existing system of social and political inequality. This objective, with its emphasis on class distinction, was too reactionary for American tastes. President Theodore Roosevelt, who favored the adaptation of the German system to American conditions, did justify governmental action on nationalistic grounds, but his objective was to preserve a democratic way of life. His position was also a minority position. The English emphasis upon the social right of an individual to a minimum level of income was too progressive to be accepted by most people in the United States around the turn of the century. The Progressive Movement that spearheaded the demand for reforms at that time was basically a middle-class movement, which tended to relate problems of economic security to individual weaknesses instead of weaknesses in the economic system. Trade unions opposed government intervention because of its paternalistic nature and its interference with the right of the individual to look after himself. Workmen's compensation, however, was acceptable to these elements because it was compatible with an individualistic, achievement-oriented society. Workmen's compensation, it was argued, was a more efficient way to handle the cost of industrial accidents; employers as well as employees would benefit from the system; and the defects in the existing system were readily apparent. When the time came to expand the social-insurance system much further in 1935, the public had to be persuaded that the action was consistent with efficiency, self-help, freedom, and thrift. The characteristics of the proposed program and their present form reflect this concern.

Second, despite the fact that many United States workers received low wages, worked under extremely poor conditions, and were subjected to severe spells of unemployment, they were considerably better off than their counterparts in Europe.

Third, private employee-benefit plans and private individual insurance were much more fully developed in the United States. The lag in the development of the social-insurance system also gave the private system more time to develop.

[3] This theme has been skillfully developed by Gaston Rimlinger in "American Social Security in a European Perspective," a paper published in W. G. Bowen, F. H. Harbison, R. A. Lester, and H. M. Somers, "The Princeton Symposium on the American System of Social Insurance," pp. 213–232.

Finally, no small factor in slowing up the adoption of social-security measures in this nation was the form of government. It was, until the 1930's, generally held that the powers of the federal government were not broad enough to include general provision of social insurance. So far as the power to do so existed, it lay in the police powers of the several states. Even there the power was not undisputed. Several of the early workmen's compensation laws were held unconstitutional by state courts as violating constitutional provisions, notably those forbidding the taking of property without the due process of law.[4] Later decisions have taken a broader point of view, and state workmen's compensation laws, both elective and compulsory, have been upheld by the Supreme Court of the United States. Until the passage of the Social Security Act in 1935, federal legislation in this field had been confined to federal employees, employees in interstate commerce, maritime workers, and employees in the District of Columbia, with some minor instances of grants-in-aid of state measures.[5]

Under these circumstances each measure has had to wait until the public attitude in an individual state had led its own legislature to adopt it. As the number of states adopting a particular policy (e.g., workmen's compensation) has increased, the popular demand for similar legislation in other states has correspondingly increased, and opposition has diminished. Further, although provisions of earlier laws have influenced the form of statutes enacted by those states whose action came later, local considerations have led to many variations in the amounts and conditions of benefits, the sources of funds from which they are to be paid, and administrative procedure.

The several states differ in the extent of their natural resources and in type and degree of economic development. Despite freedom of migration between states, they differ also in the dominant racial stocks and in the traditions and outlook of their populations. Some are notably progressive, and others are equally notable for their backwardness both in economic development and in social outlook. The more progressive states are leaders in the adoption of social legislation. But the regulation of commerce between the states is delegated by the Constitution to the federal government, and so far as the law can make it so, commerce between the states is free and unrestricted. The businesses of each state are in free and open competition with similar businesses in other states, for both domestic and foreign markets. If burdens in the form of taxes or other regulations are imposed upon the businesses of one jurisdiction in excess of those borne by competitors domiciled elsewhere, the

[4] See *Ives v. So. Buffalo Ry. Co.*, 201 N.Y. 271 (1911).

[5] In a series of decisions in 1937 the Supreme Court upheld the constitutionality of the Social Security Act and in general the power of Congress to enact such legislation. In one case (*Helvering et al. v. Davis*, 301 U.S. 619) it rested the decision squarely on the general-welfare clause.

former feel handicapped in the markets. Business interests are not slow to bring this fact to the attention of legislators when new social legislation is under consideration. It is strongly urged that leadership in such matters may be purchased at too high a price. There are even threats of removal of enterprises across state borders, though few if any cases can be found where such action was due solely to this reason. Counterarguments, based upon the probability of greater efficiency of labor under better conditions, are advanced and sometimes accepted.

The Great Depression

The sudden plunge into the depression of the 1930's changed forever the nation's economic, political, and social climate. About one-quarter of the population was unemployed during the average month in 1932 and 1933, and many persons who were conservative, thrifty, industrious, and educated found their life savings exhausted and lost their homes through mortgage foreclosures. Belief in the ability of an individual to overcome most adversities through his own efforts was severely shaken. People became more ready to accept government intervention, including action by the federal government.

At first the states acted by passing more old-age assistance and mothers' aid laws, but these aided relatively few people because of financial difficulties. Some states assumed some responsibility for the unemployed. By 1931 President Hoover favored some direct federal intervention, and at his suggestion Congress established the Reconstruction Finance Corporation, which made loans to businesses in trouble, and passed the Emergency Relief and Construction Act of 1932, which made loans to states for public-works projects. President Roosevelt was elected on a platform calling for more extensive federal action. Between 1933 and 1935 his "New Deal" included several programs for employing young men on conservation projects, distributing surplus food to the needy, and making grants to states for direct relief and for work relief.

The Social Security Act of 1935

In June, 1934, President Roosevelt appointed a Committee on Economic Security to study the general problem of economic security. This committee, composed of four cabinet members and the Federal Emergency Relief Administrator, with Professor Edwin Witte, of the University of Wisconsin, as executive director, reported to the President on Jan. 15, 1935. They recommended a program which is best characterized by their own statement:[6]

[6] *Report to the President of the Committee on Economic Security*, p. 50.

> The program for economic security we suggest follows no single pattern. It is broader than social insurance and does not attempt merely to copy European methods. In placing primary emphasis on employment, rather than unemployment compensation, we differ fundamentally from those who see social insurance as an all-sufficient program for economic security. We recommend wide application of the principles of social insurance, but not without deviation from European models. Where other measures seemed more appropriate to our background or present situation, we have not hesitated to recommend them in preference to the European practices. In doing so we have recommended the measures at this time which seemed best calculated under our American conditions to protect individuals in the years immediately ahead from hazards which plunge them into destitution and dependency.

Out of their recommendations, including drafts of bills, emerged the Social Security Act, approved Aug. 14, 1935, and becoming effective, in part, in respect of the period commencing July 1, 1935, and in part later. The broad program recommended by the committee and its prompt adoption with little change by Congress were probably due in no small part to the depression then current. The first paragraph of the report reflects its impact on the committee:[7]

> The need of the people of this country for "some safeguard against misfortunes which cannot be wholly eliminated in this man-made world of ours" is tragically apparent at this time, when 18,000,000 people, including children and aged, are dependent upon emergency relief for their subsistence and approximately 10,000,000 workers have no employment other than relief work. Many millions more have lost their entire savings, and there has occurred a very great decrease in earnings. The ravages of probably the worst depression of all time have been accentuated by greater urbanization, with the consequent total dependence of a majority of our people on their earnings in industry.

The act, in its original form, provided for old-age benefits and for public-health work, to be administered by the federal government. Provision was also made for grants to the states for old-age assistance to needy individuals, for administration of unemployment compensation, for aid to dependent children, for maternal and child welfare, and for aid to the blind. Under a title technically independent of, but clearly in support of, old-age benefits, provision was made for an income tax on employees and an excise tax on employers; and under another an excise tax was imposed on employers of eight or more employees to encourage states to enact unemployment-com-

[7] *Ibid.*, p. 1.

pensation laws and, presumably, to furnish funds for grants to states for the administration of such laws.

The Social Security Board was set up as an independent body to administer the act and to study and make recommendations "as to the most effective methods of providing economic security through social insurance, and as to legislation and matter of administrative policy concerning old-age pensions, unemployment compensation, accident compensation, and related subjects." The Board took these ancillary duties seriously and was very active in making studies and recommendations and in bringing them to the attention of the public and of Congress.

The Social Security Act, as amended, now provides for the items included originally, with the following changes: old-age benefits have developed into old-age, survivors, disability, and health insurance; the public-health title has been repealed, and provision under this head is now made by the Public Health Service Act; the tax titles are now included in the Internal Revenue Code; and titles have been added to provide for advances to state unemployment funds, for reconversion unemployment benefits for seamen, for unemployment compensation for federal employees and for ex-servicemen, and for grants to states for aid to the permanently and totally disabled and for aid to the medically indigent. Administration of OASDHI and of the grants-in-aid to public-assistance programs is handled by the Social Security Administration and the Social and Rehabilitation Service, both of which are part of the Department of Health, Education and Welfare. The provisions dealing with unemployment compensation are administered by the Secretary of Labor.

The new fields covered by the Social Security Act, entrance of the federal government into areas formerly thought of as the concern of the states, the magnitude of the operations under it, and the new philosophy that it represents make it the second great landmark (workmen's compensation was the first) in the development of social insurance in the United States.

The Present

At present both political parties favor the continuance and the eventual expansion of the present social-security system. They differ in degree on the speed with which such changes should take place and the nature of the changes. The depression, with its emergency needs, is becoming a dim memory, but the current population, although considerably more affluent, has a more developed social conscience and a much better understanding and appreciation of the insurance and social-insurance mechanisms. Labor unions are more powerful and, instead of being suspicious of government intervention as they were before 1930, now strongly favor social-security legislation. The aged have

also increased in numbers and in political influence. Even the classical economic theory of Alfred Marshall has given way to the new economics of J. M. Keynes and the President's Council of Economic Advisers. Despite the general acceptance of a social-security system, however, there remain many highly significant differences of opinion on the detailed programs. Some of the more important issues surrounding particular programs are presented in the next chapter.

A SUMMARY VIEW OF THE PRESENT SYSTEM

Before turning to a more detailed discussion of the more important programs in the next chapter, it is instructive to describe briefly the major components of the present system, their basic purpose, and some measures of their relative importance. Such a summary view will better enable the reader to place each program in proper perspective and to note gaps and overlaps in the system as a whole. A few of the more limited programs will be discussed in more detail than their relative importance justifies because they will not be considered in the next chapter.

The most important social-insurance program is Old-Age, Survivors, Disability, and Health Insurance (OASDHI), which can be subdivided into four components: (1) Old-Age and Survivors Insurance (OASI), which provides retirement benefits and survivorship benefits for the dependents of deceased workers, (2) Disability Insurance (DI), which makes disability-income payments to persons with long-term total disabilities, (3) the recently established Hospital Insurance (HI) program, which covers the cost of certain hospital, extended-care facility, and home health services for persons aged 65 or over, and (4) Supplementary Medical Insurance (SMI), which supplements the HI program primarily through coverage of the cost of physicians' and surgeons' services in a hospital, at the doctor's office, or in the patient's home. Hospital Insurance and Supplementary Medical Insurance are popularly known as Medicare. Table 36–1 shows the relative importance of this program and the others to be discussed below in terms of the number of persons in paid employment covered[6] in December, 1967, the average monthly number of persons receiving benefits in 1967, and the total dollar benefits paid in that year.

The Railroad Retirement System is a special program developed by the federal government for railroad workers by an act (the Railroad Retirement Act of 1934) that antedates the Social Security Act. At the time Congress

[6] The figures in the table do not include the millions of nonworkers who were entitled to benefits as dependents of covered workers or, under some programs, the nonworkers who were entitled to benefits because of past work records.

Table 36–1 ESTIMATED BENEFICIARIES OF CASH PAYMENTS UNDER SELECTED SOCIAL-SECURITY PROGRAMS AT END OF DECEMBER, 1967 AND THE CASH OR MEDICAL-CARE BENEFIT PAYMENTS IN 1967
(In millions)

Program	Number of persons receiving cash benefits	Total benefit amounts
OASDHI:		
OASDI	24	$21,406
HI	...	3,353
SMI	...	1,197
Railroad Retirement System:		
Retirement, long-term disability, and survivorship benefits	1	1,296
Short-term disability benefits	*	35
Unemployment benefits	*	41
Veterans' pension and compensation programs	5	5,784
Unemployment compensation programs	1	2,236
State temporary disability benefits	n.a.	470
Workmen's compensation	n.a.	1,975
Cash-benefit payments under public-assistance programs:		
OAA	2	1,702
ADFC	5	2,263
APTD	1	574
AB	*	87
General assistance	1	335
Vendor payments for medical services under public-assistance programs:		
MA	...	2,460
Other	...	357

* Less than 500,000.
Source: *Social Security Bulletin*, vol. 31, no. 5 (May, 1968), pp. 29–31, 41, and 49.

was concerned with the orderly retirement of older workers whose continued employment might endanger the safety of passengers and freight. Existing private plans were experiencing financial difficulties. The present system provides retirement benefits, survivorship benefits, long-term disability benefits, short-term disability benefits, and unemployment benefits. Railroad workers are also covered under HI and SMI. The retirement, survivorship, and disability benefits are higher than equivalent OASDI benefits because this system

is considered to be a substitute for OASDI plus a private employee-benefit plan. Railroad workers are not covered under OASDI unless they have less than 10 years of railroad service, in which case their earnings are treated as covered wages under OASDI. The two systems are also interrelated in other ways too complicated to explain here. The system benefits are financed by substantial employer and employee contributions.

Public-employee retirement programs include the Civil Service Retirement System, other programs for federal employees, and state and local retirement programs for teachers, policemen, firemen, and other public employees. State and local public employees are in many instances also covered under OASDHI.

Veterans' pension and compensation programs cover another special group. Compensation for service-connected disability and death is an important benefit. Pensions for nonservice-connected disability and death are paid on a sliding scale based on need. The Veterans Administration also provides hospital services and medical care for veterans with service-connected disabilities and for other veterans who can demonstrate need. The federal government has also provided life insurance, with disability-income features, for members of the armed forces since the First World War. Both United States Government Life Insurance (USGLI), which was first provided, and National Service Life Insurance (NSLI), the system which replaced it in 1940, were brought into being primarily because members of the armed forces are, in time of war, unacceptable as applicants for insurance with private insurers. Under both of these plans, provision was made for the government to bear the costs of benefits paid on account of service-connected deaths or disabilities, and also expenses of administration. Contracts of insurance were sold to those eligible for them at rates of premium that proved to be considerably higher than was necessary to meet the cost of the nonservice-connected losses, and substantial dividends have been paid to insureds.

A new plan was adopted for armed-forces personnel serving on or after June 27, 1950, the date of commencement of the United States action in Korea. Issuance of new National Service Life Insurance was discontinued, with certain exceptions, and provision was made for gratuitous indemnity to specified close relatives of each person in service. The amount was $10,000, inclusive of any USGLI or NSLI carried, though such insurance might be discontinued and later reinstated or again purchased. Certain limited privileges to purchase insurance after separation from the services were given to persons entitled to gratuitous indemnity.

In 1956 the government stopped issuing any new insurance protection. Servicemen are currently covered under OASDI and in addition can secure up to $10,000 protection under a group plan underwritten by private insurers and subsidized by the government to cover the extra war risk.

State unemployment-compensation programs provide temporary unemployment insurance for covered workers who face the threat of unemployment. State temporary-disability-insurance legislation, limited to four states, requires employers to provide this type of protection for their employees against nonoccupational injuries and sickness.

Public-assistance programs provide needy persons with cash benefits and make payments (called *vendor* payments) to hospitals, doctors, and the like, for services rendered. The cash-benefit programs include the four categorical plans financed largely through federal grants-in-aid—Old-age Assistance (OAA), Aid to Families with Dependent Children (AFDC), Aid to the Blind (AB), and Aid to the Permanently and Totally Disabled (APTD)—and general assistance, the residual plan operated solely by the state and local governments. Vendor payments are made under these five plans but also under Medical Assistance for the Aged (MAA), a program for the *medically* indigent aged who can meet other bills but not medical expenses, and Medical Assistance (MA), which by 1970 is expected to absorb all of the vendor-payment plans.

All of these programs, except the special programs for railroad workers, public employees, and veterans, will be examined in more detail in the next chapter.

TWO PROPOSED ADDITIONS

Recently enough attention has been focused on two proposed basic changes in the nation's economic-security system to merit brief attention here. The proposed changes involve (1) family allowances and (2) a guaranteed minimum income.

Family Allowances

Family allowances or payments to families that vary in accordance with family size are an important part of the social-security system of many nations. All families would be eligible for these payments, regardless of their income and whether they had experienced any unemployment, death, retirement, poor health, or other traditional causes of financial loss. The risk handled by family allowances is that the family income will not grow rapidly enough to meet the extra demands imposed by family growth, no matter what the reason for this failure may be.[9] Recent discoveries that children constitute a rather large proportion of those living below the poverty level have renewed interest in this proposal.

Arguments in favor of family allowances include the following: (1) Family allowances would be superior to public assistance because there would be no

[9] For a recent comprehensive article on family allowances, see Victor Gerdes, "Social Security and Family Income Requirements."

means test and the benefit amounts would be more certain. (2) If the allowances were generous enough, they would replace public assistance. (3) Discrimination of various sorts against children born into large families would be diminished. (4) Family allowances would make it possible for parents to assume more parental responsibility and to command more respect from their children because they would not have to be away from home so often to earn the same income or because the increased income would better enable them to care for their children's needs. (5) The nation's progress and strength depend largely upon the optimum use of its young manpower. Society as a whole, therefore, should be interested in the welfare of its children and be willing to contribute to the cost of family allowances. (6) No nation with a family-allowance system has ever abandoned it.

Arguments against family allowances, which have prevailed up to the present time, are as follows: (1) Even a modest program would be extremely costly. (2) The redistribution of income to large families is not "fair." (3) Incentives to work would be adversely affected. (4) The program would contribute to the problem of population growth, particularly among the poor. (5) Parental responsibility would decrease because the government has assumed financial responsibility. (6) Most families in the United States do not require assistance through family allowances.

Guaranteed Minimum Income

Guaranteed-minimum-income proposals are of much more recent origin and have assumed diverse forms.[10] Professor Milton Friedman, a distinguished conservative economist, has proposed a negative income tax that would provide persons with earnings below a certain amount a government subsidy per person that would increase as the family earnings decrease. The subsidy for a family with no earnings would be sufficient to alleviate their poverty but not eliminate it. This proposal, if adopted, would apparently replace the existing social-security system. Robert Theobald, another economist, is concerned about the reduction in jobs, particularly unskilled jobs, that the technological revolution is producing. He suggests that each member of society has a right to basic economic security. All families would receive a specified amount per adult plus an additional amount per child. Persons with private income could keep a small fraction of that income. The basic economic-security level would exceed the Friedman minimum level, but, like Friedman, Theobald apparently would abolish all existing public programs. Other proposals vary in the minimum standard of living proposed, their attention to the maintenance of work

[10] For a description of various proposals and some interesting evaluations of each, see George F. Rohrlich, "Guaranteed-Minimum-Income Proposals and the Unfinished Business of Social Security," and "A Symposium: Negative Income Tax Proposals."

incentives, and their treatment of existing programs. Most would abolish or greatly reduce the role of public assistance but would continue OASDHI and unemployment compensation.

Guaranteed-minimum-income proposals have been supported on one or more of the following grounds: (1) Poverty would be eliminated or at least reduced. (2) Public assistance could be eliminated or at least reduced in importance. (3) The tax system already serves certain welfare objectives, as evidenced by special deductions for the aged and the exemptions for dependents, but these features benefit most those with higher incomes. (4) The proposal would eliminate discrimination against large families at least among low-income families, and achieve the other advantages of a family-allowance program.

Criticisms of these proposals usually center upon the following points: (1) The plan would reduce incentives to seek work. It is better to train the unskilled to do the many jobs that will have to be done. (2) The plan would substitute an untried experiment for an economic-security system based upon an entirely different philosophy and tested over a long period of time. (3) The plan would be extremely costly, even assuming abandonment of the present system.[11] (4) The arguments that family allowances would encourage large families, result in an "unfair" redistribution of income, and reduce parental responsibility also apply to this proposal.

The future of the guaranteed-minimum-income concept is uncertain, but these proposals are receiving far more serious consideration today than was thought possible only a decade ago.

QUESTIONS

1 Distinguish between:
   - **a** preventive and alleviative programs,
   - **b** social insurance and public assistance,
   - **c** social adequacy and private equity.

2 Is social insurance "insurance"? How does it resemble private insurance?

3 If you were asked to develop a social-security program for providing medical care, what questions would you have to consider?

4 How do you account for the present extensive social-security system in the United States? Why did it take so long to develop?

5 What are the principal social-insurance and public-assistance programs dealing with death? With old age? With unemployment? With poor health?

6 **a** Do you favor family allowances? Why?
   b Do you favor a guaranteed minimum income? Why?

[11] If OASDHI were abolished as well as public assistance, many covered persons would have to devote more resources to private protection measures, thus reducing their ability to pay taxes.

37
THE SOCIAL-SECURITY SYSTEM: PROGRAMS

Any explanation of the social-security programs in existence at any point in time is subject to rapid obsolescence because these programs are constantly being reviewed and there are many pressures for change. Nevertheless one cannot fully understand a social-security system unless one knows something about current-program eligibility requirements, benefits, and financing. Furthermore, although the details of the programs change almost annually, the general structure of the programs is much more resistant to change.

This chapter is concerned only with the more important components of the social-security system: (1) Old-Age, Survivors, Disability, and Health Insurance, (2) unemployment compensation, (3) workmen's compensation, (4) compulsory temporary-disability insurance, and (5) public-assistance programs.

OLD-AGE, SURVIVORS, DISABILITY, AND HEALTH INSURANCE

Old-Age, Survivors, Disability, and Health Insurance can be divided into three sub-programs: (1) Old-Age, Survivors, and Disability Insurance (OASDI), (2) Hospital Insurance (HI), and (3) Supplementary Medical Insurance (SMI). The last two programs are more popularly known as Medicare.

Old-Age, Survivors, and Disability Insurance

Eligibility Requirements. To receive OASDI benefits most persons must be *fully insured, currently insured,* or both. Fully insured persons qualify for most of the types of benefit provided under the program; currently insured persons are eligible only for some survivorship benefits.

A person's status is determined by comparing the number of quarters of coverage he has earned with some standard. A quarter of coverage is a calendar quarter during which he received $50 or more in covered employ-

ment.[1] Most types of employment are covered on a compulsory basis. Some workers, such as self-employed persons, agricultural laborers, and domestic workers, are covered only if their earnings exceed some specified amount. Others, such as members of certain religious sects, employees of nonprofit organizations, and state and local government employees, are subject to special treatment which gives some of these workers the opportunity to elect whether they will be covered. Most family employees, student workers in institutions of learning, long-service railroad workers, and federal-government civilian workers are among the few employees excluded.

A person is fully insured at the time he retires, dies, or becomes disabled if his quarters of coverage equal or exceed the number of years elapsing between the end of the year in which he was aged 21 and the beginning of the year in which he became or would become aged 65 (62 for women), died, or became disabled, whichever occurs first. However, if the person was aged 21 before 1951, the starting point is the end of 1950. The minimum number of quarters required is six; the maximum 40. Thus many persons will acquire and retain this status by working 10 years in covered employment.

A person is currently insured if six of the last 13 calendar quarters, including the quarter in which he dies or becomes eligible for retirement or disability benefits, are quarters of coverage. A new worker, therefore, can become currently insured in a short period of time. A person can be fully insured without being currently insured, and vice versa.

To receive disability benefits, a person must first be fully insured at the time his disability commences. Second, 20 of the last 40 calendar quarters must be quarters of coverage. Third, he must be unable to engage in any substantially gainful activity because of a physical or mental impairment for at least six consecutive months, and this impairment must be expected either to result in death or to last at least 12 months. Somewhat more liberal requirements apply to blind persons and to workers disabled before they reach age 31.

Under a transitional provision persons who became 72 before 1968 receive payments (subject to certain deductions for other government pension payments) of $40 a month ($60 for a married couple) even though they are not fully insured or in fact never worked in covered employment.

Benefits. The principal *retirement* benefit is a monthly income for life payable to retired workers, aged 65 and over. This monthly income is equal to the primary insurance amount, which also serves as the base for determining all other benefits under the program.

[1] Self-employed persons receive credit for four quarters of coverage if their annual earnings exceed $400. Others earn four quarters of coverage if their wages or salaries exceed the maximum earnings base, currently $7,800.

In most cases the primary insurance amount is a function of the worker's average monthly earnings subject to OASDI taxes during the period beginning with the year in which the worker was aged 22 (1951 if the worker was aged 22 before that year) and ending with the year in which the worker became or would become age 65, dies, or becomes disabled, whichever happens first. Periods of low monthly earnings or no earnings depress the average monthly earnings because they are included in the computation. The maximum earnings creditable in any year is the maximum earnings base, currently $7,800 but only $6,600 during 1966 and 1967 and less before that. However, the 5 years of lowest earnings are omitted from the computation. Furthermore, years before and after the base period can be substituted for years within that period if this substitution would benefit the worker.

The formula for the primary insurance amount (increased slightly for the lower average monthly earnings) is as follows:

71.16% of the first $110 of average monthly earnings plus
25.88% of the next $290 plus
24.18% of the next $150 plus
28.43% of the next $100.

However, there is a minimum benefit of $55. Because the maximum average monthly earnings is $7,800, the maximum primary insurance amount is $218. Table 37–1 presents the primary insurance amount developed for some selected average-monthly-earnings assumptions.

The formula, subject to the minimum-benefit constraint, develops a primary insurance amount that is the same for all average monthly earnings up to $67. The primary insurance amount increases for earnings above this amount, but the ratio of the primary insurance amount to the average monthly earnings decreases as those earnings increase. The formula is a compromise between the desire to provide socially adequate benefits for all workers while preserving some relationship between average taxable monthly earnings and benefits.

Workers who wish to retire as early as age 62 can do so but their benefit is reduced by 5/9 of 1 per cent for each month they retire prior to their sixty-fifth birthday.

Workers under age 72 are permitted to earn up to $1,680 a year in wages, salaries, or self-employment income without losing any benefit. If they earn more than $1,680, they lose $.50 in benefits for every dollar of the next $1,200 in earnings and $1 in benefits for every dollar earned in excess of $2,880. Workers aged 72 or over are not subject to this earnings test.

Additional retirement benefits are payable when there are dependents. For example, a wife, aged 65, can receive 50 per cent of the primary insurance amount. Reduced benefits are payable as early as age 62. If there are children under age 18, each child receives 50 per cent. Their mother also

receives 50 per cent. If the children go to an accredited school, their benefit continues to age 22, but the mother's benefit stops when she no longer has a child under age 18 in her care. The maximum family benefit is usually 80 per cent of the first $436 of average monthly earnings plus 40 per cent of the next $214. Some illustrative family benefits are presented in Table 37–1.

The major *survivorship* benefits are those for widows and surviving children. If a fully or currently insured worker dies, each of his children under age 18 receives a benefit equal to 75 per cent of his primary insurance amount computed to the year of death. Their mother also receives 75 per cent. If the children attend an accredited school, their benefit continues until they are age 22, but the mother's benefit stops when the youngest child reaches age 18 or if she remarries. The widow of a fully insured worker receives a monthly income for life equal to 82.5 per cent of his primary insurance amount, beginning at age 62. A reduced benefit is available as early as age 60. Remarriage will also stop this benefit, but if the widow remarries after attaining age 60, her benefit is reduced, not stopped. A lump-sum benefit of three times the primary insurance amount, but not in excess of $255, is also payable to the survivors of a fully or currently insured worker. These benefits are subject to the same family maxima as the retirement benefits. Each survivor's benefit will be reduced according to the formula cited above if he earns more than $1,680. Some illustrative benefits are presented in Table 37–1.

The program provides four major types of *disability* benefits. First, years included wholly or partly in a period of disability are not counted as elapsed years in determining the person's insured status or his average monthly earnings. This "freeze" thus protects a fully or currently insured worker from losing this status prior to his death or retirement age or from receiving reduced death or retirement benefits because of years of reduced earnings. Second, after a six-month waiting period, the worker receives a monthly benefit equal to the primary insurance amount computed in the same way as if he had retired instead of becoming disabled. This income continues until the worker recovers, dies, or reaches age 65, at which time he becomes eligible for the same monthly amount as a retirement benefit. Benefits for dependents are computed and are reduced for outside earnings in the same manner as the benefits for dependents of retired workers. Third, if a child is totally disabled before age 18, the age 18 limitation on a child's benefit and on the mother's benefit does not apply. Fourth, disabled widows can under certain conditions receive survivorship benefits as early as age 50.

Financing. The special transitional benefits for persons aged 72 before 1968 are financed out of general revenues, but the other benefits and the expenses of administration are supported by an earmarked payroll tax levied at present

Table 37–1 ILLUSTRATIVE MONTHLY CASH BENEFITS UNDER OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE (Social Security Amendments of 1967)

Family situation	Average monthly earnings						
	$67 or less	$150	$250	$350	$450	$550	$650
Primary insurance amount	$ 55.00	$ 88.40	$115.00	$140.40	$165.00	$189.90	$218.00
Retirement:							
Worker, aged 65	55.00	88.40	115.00	140.40	165.00	189.90	218.00
Worker, aged 62	44.00	70.80	92.00	112.40	132.00	152.00	174.40
Wife, aged 65	27.50	44.20	57.50	70.20	82.50	95.00	109.00
Wife, aged 62	20.70	33.20	43.20	52.70	61.90	71.30	78.80
One child	27.50	44.20	57.50	70.20	82.50	95.00	109.00
Survivorship:							
Widow, aged 62	55.00	73.00	94.90	115.90	136.20	156.70	179.90
Widow, aged 60, no child	47.70	63.30	82.30	100.50	118.10	135.90	156.00
Widow under 62 and 1 child	82.50	132.60	172.60	210.60	247.60	285.00	327.00
Widow under 62 and 2 children	82.50	132.60	202.40	280.80	354.40	395.60	434.40
Lump-sum death benefit	165.00	255.00	255.00	255.00	255.00	255.00	255.00
Disability:							
Worker	55.00	88.40	115.00	140.40	165.00	189.90	218.00
Wife with child in her care	27.50	44.20	57.50	70.20	82.50	95.00	109.00
One child	27.50	44.20	57.50	70.20	82.50	95.00	109.00
Disabled widow at age 50	33.40	44.30	57.60	70.30	82.70	95.10	109.20
Maximum family benefit	82.50	132.60	202.40	280.80	354.40	395.60	434.40

on the first $7,800 of earnings. The current and scheduled contribution rates are as follows:

Year	Employee	Employer	Self-employed
1969–1970	4.2%	4.2%	6.3%
1971–1972	4.6	4.6	6.9
1973 on	5.0	5.0	7.0

The contributions collected according to this schedule less the amount allocated to disability-income benefits (0.475 per cent on employees and on employers and 0.7125 per cent on the self-employed) are appropriated to the Old-Age and Survivors Insurance Trust Fund. The disability-income contributions are appropriated to the Disability Insurance Trust Fund. The monies in these funds not needed for current benefits or expenses are invested in interest-bearing United States government obligations or securities guaranteed as to principal and interest by the United States.

The scheduled contribution rates are designed to enable the program to remain self-supporting for the next 75 years with a trust fund at the end of that period equal to one year's disbursements. The scheduled contribution rates are reviewed periodically, and in connection with all major proposals for change in the program, by actuaries of the Social Security Administration. These estimates are affected by many variables whose future course is sometimes extremely difficult to evaluate. In addition to serving as a contingency fund, the trust funds, through interest earnings, reduce the required contribution rates. At the close of 1967 the OASI Trust Fund had assets valued at $24.2 billion; the DI Trust Fund assets were valued at $2.0 billion.

Issues. Only a sample of the many issues surrounding OASDI can be discussed here. These issues will be categorized according to whether they affect coverage, benefits, or financing.

Because most employments are now covered under OASDI, there is much less pressure than in the past for the inclusion of new occupations. However, there is some support for coordinating the Civil Service Retirement System with OASDI in the same way as the Railroad Retirement System. The ultimate goal, in the eyes of many, is universal coverage. A related proposal would grant some OASDI benefits immediately to all aged persons. The transitional benefits to those aged 72 before 1968 are a step in this direction. This extension of benefits has been justified mainly on the grounds that it would improve the situation of aged nonbeneficiaries, reduce public assistance costs, and correct the discrimination against aged persons who were not

covered under OASDI simply because they were born too soon. In opposition it has been suggested that this proposal would destroy the fundamental principle underlying OASDI that benefits be related to contributions to the program, benefit some aged persons who *elected* not to join the system, and shift the tax burden from progressive income taxes that provide the main support for public assistance to regressive payroll contributions. The relationship between the benefit amounts to be received by these persons and those received by contributors to the system also poses some interesting philosophical questions.

Several features of the benefit structure are highly controversial. First, there is strong support for increasing the minimum benefit, but supporters disagree on what the increase should be. One often-quoted suggestion is that regular full-time workers at low earnings levels should receive enough money to make it unnecessary for them to apply for public assistance. A separate minimum benefit would be paid to persons with low average monthly earnings who had not been regular full-time workers. Second, the balance between social adequacy and private equity implicit in the present benefit structure is an unstable one. One proposal, not seriously considered at this time, is that all beneficiaries should receive the same benefit, regardless of their past earnings records. At the other extreme, a few critics argue that benefits should be related proportionately to average monthly earnings. Between these two extremes there are numerous possible positions. For example, each of the percentages in the present benefit formula could be raised or lowered. The 71.16 per cent in the present formula could be applied to a higher or lower portion of average monthly earnings than $110. The desired relationships between benefits and contributions depends, among other things, on one's preferred balance between public and private responsibility for protection above the minimum benefit level, one's concept of a fair redistribution of income, and one's degree of concern about possible adverse effects upon the private insurance business. Third, there are several philosophies concerning the maximum earnings base. Because the maximum benefit depends upon the maximum average monthly earnings, one's philosophy concerning this base has benefit implications as well as financing implications. The choice, therefore, depends in part upon the three factors just mentioned. In addition, some persons suggest maintaining the relationship between the proportion of total payroll that is taxed or the proportion of workers with all their earnings covered that existed during some earlier period;[2] others would equate the base to the average wage of full-time workers.

[2] For example, under the original $3,000 base, 92 per cent of the covered payroll was taxed in the late 1930's. Ninety-eight per cent of the workers had all their earnings covered. A base of $14,500 would have been necessary in 1965 to maintain this relationship.

Fourth, the earnings test that causes some beneficiaries earning more than $1,680 a year to lose their benefits or to receive reduced benefits has been attacked on the grounds that it forces some able aged persons out of the labor force or prevents them from obtaining benefits to which they are allegedly entitled because they have paid for them through contributions to the program. Removing the test, however, would increase the cost of the program by about 10 per cent to meet what many consider to be a relatively unimportant need. Finally, it has been suggested that the benefits and the earnings base be subject to certain automatic adjustments instead of depending upon *ad hoc* adjustments by Congress. For example, benefits could be adjusted according to changes in the Consumers' Price Index, or the earnings base could be adjusted according to one of the principles noted above. No action has been taken on this suggestion primarily because the legislators cannot agree on the principles to be built into the system, they believe that a frequent review of the entire program is in the public interest, and they do not want to lose the political credits associated with increasing benefit levels.

One important financing issue is whether contributions should be increased by raising the earnings base or the contribution rate. The relative impact upon high- and low-paid workers is a major consideration, as is the effect of the maximum earnings base upon the maximum benefit. It is also argued that a high earnings base would enable the program to capture more contributions in periods of economic prosperity and to reduce contributions in periods of economic decline. A second major financing issue is the role of the trust funds. Some would favor higher contribution rates now to build up the trust funds to avoid passing to future generations the cost of benefits to this generation and to make the public more conscious of the additional costs of proposed liberalizations in the program. On the other hand, others are concerned about the "fiscal drag" imposed upon the economy by the current or higher contribution rates. Future generations, it is argued, will benefit from many expenditures financed by the current generation through other taxes. Furthermore, large trust funds may provide an excuse for undue liberalizations in the program instead of discouraging them. The most recent and most controversial issue is the use of general revenues to pay part of the cost of the system. Because of the windfall benefits provided many aged persons during the early years of the program and the emphasis upon socially adequate benefits for workers with low earnings or many dependents, the contributions paid by many younger workers and their employers have reached the level at which they could be used to obtain superior benefits from private insurers. To correct this situation and to make possible some benefit increases and other liberalizations, it has been suggested that one-third of the cost of the benefits be financed out of general revenues. Current employees and their employers would then be paying approximately the cost of the

benefits for current employees. The fundamental principle of contribution-related benefits would be retained and benefit liberalizations would require increased contributions. In opposition it has been argued that employer contributions are not made in behalf of their own employees but as their share of the cost of the entire program, that it is unfair to shift the burden of OASDI benefits to general revenues, that benefits will be unduly liberalized when the new funds are made available, and that the role of general revenues will be expanded beyond the proposed one-third.

Hospital Insurance

All employments covered under OASDI plus railroad employment are covered under the new (1965) Hospital Insurance (HI) program, also known as Part A of Medicare. OASDI and Railroad Retirement System beneficiaries, aged 65 or over, are eligible for HI benefits. Also eligible are those aged persons who would be receiving OASDI benefits except for the fact that their current earnings cause them to lose their benefits. As a transitional feature, benefits are also paid to most persons, aged 65 or over before 1968, who are not covered under OASDI or the railroad program. Persons aged 65 after 1967 but before 1973 (1971 for women) must have some quarters of coverage but they need not be fully or currently insured.

The program provides (1) hospital benefits, (2) extended-care facility benefits, and (3) home health-services benefits. The hospital benefits include such items as room and board in a semiprivate room, general nursing services, operating room, laboratory tests and X-rays, drugs, dressings, and the services of interns and residents in training. The maximum duration is 90 days in a single "spell of illness," which begins on the first day that the person receives hospital or extended-care services and ends when a person has not been in any hospital or extended-care facility for 60 consecutive days. Each person also has a "lifetime reserve" of 60 additional benefit days which can be used to supplement the 90 days provided for each spell of illness. Each time this reserve is used, the number of days remaining is reduced. There is a $44 deductible applicable to each spell of illness, and after the person has received 60 days of care in a hospital, there is a deductible of $11 a day for the next 30 days. A deductible of $22 applies to expenses incurred during each "reserve" day. The program provides for automatic adjustment of these deductibles to reflect changes in hospital costs. The first adjustment became effective in 1969. For example, until 1969 the deductible applicable to each spell of illness was $40.

Similar services are covered in an extended-care facility after the person has been in the hospital for at least three days and, although he is not well,

he no longer needs intensive hospital care. The maximum duration is 100 days in a spell of illness. There is a deductible of $5.50 a day (subject to future automatic adjustments) after the first 20 days.

Home health services following a hospitalization period of three days include such items as part-time visiting-nursing care and use of medical appliances but not full-time nursing care or drugs. The maximum duration is 100 visits in the year following discharge from a hospital or extended-care facility.

The transitional benefits for aged persons not covered under OASDI are financed through general revenues, but most HI benefits are financed through a contribution rate levied on the OASDI maximum earnings base. The scheduled contribution rates are as follows:

Year	Employee	Employer	Self-employed
1969–1972	0.6 %	0.6 %	0.6 %
1973–1975	0.65	0.65	0.65
1976–1979	0.7	0.7	0.7
1980–1986	0.8	0.8	0.8
1987 on	0.9	0.9	0.9

These contributions are appropriated to a Hospital Insurance Trust Fund from which benefits and expenses are paid.

An unusual feature of this program is the involvement of private insurers in the administration of the program. Each hospital or other provider of services can deal directly with the federal government, but most have elected to receive their payments through a fiscal intermediary approved by the federal government—usually a Blue Cross association or some commercial insurer. These fiscal intermediaries are reimbursed for their reasonable costs of administration. The experience of these agencies in dealing with overutilization of services and excessive charges was partially responsible for involving them in the program. Hospitals and other agencies are themselves required to meet certain standards and to take steps to discourage overutilization of their services.

Although this program was established after extensive debate and much controversy, pressures have already developed to extend the program to other OASDI beneficiaries such as the disabled and survivors of deceased persons. An extreme position would make all members of the population eligible for benefits, thus substituting to a large extent public protection for private protection. Pressures have also been exerted upon the benefit structure. Hospital benefits, for example, have already been extended from the original 90-day maximum duration. One factor retarding liberalizations in the program

is the fact that costs have risen somewhat faster than expected, primarily because of rising hospital and other medical charges, thus forcing an upward revision in the contribution rate base and rate schedule effective in 1968. The impact of HI upon relative hospital charges, the nature of medical care, and private health insurance are other issues that have been widely discussed.

Supplementary Medical Insurance

Unlike the other OASDHI programs, Supplementary Medical Insurance (SMI), also known as Part B of Medicare, is voluntary. Subject to certain exceptions, all aged persons are eligible to participate. However, in order to avoid adverse selection against the program, persons wishing to participate must elect coverage during specified enrollment periods.

The benefits include doctors' services, certain medical services and supplies such as artificial limbs and ambulance services, and the home health services covered under HI, but the patient need not be hospitalized first to receive these services. Except for a limit of 100 visits in a calendar year applicable to home health services and a special limit on the treatment of mental disorders, there is no limit on the protection afforded. However, there is a deductible equal to the first $50 of expenses incurred in a calendar year plus 20 per cent of the excess.

Aged participants pay a monthly premium of $4, which is matched by the federal government out of general revenues. These monies are appropriated to a Supplementary Medical Insurance Trust Fund. Because these premiums are based upon short-range cost estimates, they are subject to frequent changes.

Like HI, SMI involves private agencies in its administration. However, unlike HI, SMI provides two methods for paying doctors' bills. The doctor, like the hospitals under HI, may submit the claim directly to the fiscal agency; but if the doctor refuses to submit his bill to the administering agency, the patient can submit an itemized but unpaid bill for payment.

SMI is subject to the same pressures for expansion and involves the same basic issues as HI. A factor retarding expansion has been increasing costs, which caused the premium to be increased in 1968 from the original $3.

UNEMPLOYMENT COMPENSATION

Each state has an unemployment-compensation program approved by the federal government under the special taxing provisions of the Social Security Act. Under these provisions the federal government levies on covered employers a tax of 3.1 per cent on the first $3,000 earned by each employee.

Excluded employments are agriculture, domestic service, casual labor, some public service, and service for nonprofit organizations. Small employers are excluded unless they employ four or more workers on at least one day in each of 20 weeks in a calendar year. However, if the employer's state has an approved unemployment-insurance program, the maximum state tax that an employer could be required to pay, up to 2.7 per cent, can be offset against the federal tax. The remaining 0.4 per cent is used to finance the administrative costs of the federal Bureau of Employment Security and the state programs and to build up a loan fund from which the states can under certain conditions receive interest-free loans. Both the federal and the state taxes are placed in an Unemployment Trust Fund maintained by the federal government, but separate accounts are established for each state. The assets are invested in United States bonds. In view of the incentives provided under the act, it is not surprising that all jurisdictions have established approved programs.

Federal approval is easy to achieve. Employers required to pay the federal tax must be included under the state plan. Qualifications for benefits and benefit levels are not specified, but a state program cannot deny benefits to a worker who refuses new work if the job is available because of a labor dispute, if the working conditions are substantially less favorable than those for similar work, or if the worker would be required to join or not join a labor organization. All benefits must be paid through public employment services. Employers who are experience-rated must have at least one year of experience. The state must select and retain its personnel on a merit basis, provide for the full payment of compensation when due, provide for a review of its decisions, and make certain reports to the federal bureau.

State Laws

State laws vary so greatly in detail that they defy summarization beyond a certain level of detail.[3] However, a discussion of the major features of these plans is necessary in order to understand and evaluate their operations.

Coverage. About two-thirds of the states cover employment for state and local governments, but otherwise the state laws, with a few exceptions, exclude the types of occupations excluded under the federal law. Almost one-half of the states, however, cover employers of only one employee.

[3] For a detailed updated description, see "Comparison of State Unemployment Insurance Laws," published by the United States Department of Labor.

Eligibility for Benefits. To be eligible for benefits, a worker must first demonstrate his attachment to the labor force. In most states he demonstrates this attachment by having earned certain minimum wages (usually some multiple such as 1½ or 30/26 times his high-quarter earnings) during his base period, which is generally the first four of the last five completed calendar quarters prior to the date he files a claim. In addition, he must be unemployed (or working less than full time and earning less than some specified amount), he must (except in 10 states) be physically able to work, and he must be available for work; i.e., he must be willing and able to take any suitable employment. In over half the states he must in addition be actively seeking work. In all states he must register for work with the state employment service. His benefits may be postponed, reduced, or canceled if he leaves his job voluntarily without good cause, is fired because of misconduct, refuses suitable work, is idle because of a labor dispute, misrepresents the facts to receive benefits to which he is not entitled, or receives other forms of income such as wages in lieu of notice, dismissal payments, workmen's-compensation benefits, OASDI benefits, or a pension. Benefits are postponed in many states for some of these causes instead of being canceled for the duration of the worker's unemployment on the theory that after the passage of the postponement period, the person's unemployment is not attributable to the reason for which he was disqualified.

Benefits. All states except three require that an unemployed person be unemployed for one week before benefits are payable. However, once a person has satisfied this waiting-period requirement, he need not satisfy it again with respect to future spells of unemployment during a "benefit year." A benefit year is usually the year beginning with the date he files an unemployment claim.

About two-thirds of the states relate the worker's benefit during a benefit year to his earnings during that calendar quarter of his base period in which he had the highest earnings. Ten states multiply these earnings by 1/26, which would give a worker with 13 full weeks of employment about 50 per cent of his average weekly wage as a benefit. Seventeen states use lower fractions to allow for some periods of unemployment during the base period. Nine states use a lower fraction for persons with high earnings than for those with low earnings. One state pays half of the average weekly wage in the high-earnings quarter. The remaining jurisdictions relate their benefit to the worker's earnings during the entire base period. Eleven states pay additional weekly allowances for dependents.

The benefits developed by these formulas are subject to both minimum and

maximum limits. Maximum benefits without dependents' allowances range from $30 to $68 with $40 to $50 being the most common limits. If maximum dependents' allowances are included, the range is $30 to $90 except in Massachusetts, where the maximum is the worker's average weekly wage. Almost half the states now automatically adjust the maximum benefit according to changes in the average weekly wage in covered employment. Minimum benefits without dependents' benefits range from $3 to $25.

Benefits for partial unemployment are usually the weekly-benefit amount less the wages earned in the week, but some portion of the wages earned, usually $2 to $10, is disregarded in this computation.

Eight jurisdictions pay benefits for a uniform period during a benefit year to all unemployed workers. The remainder limit the maximum duration in two ways. First, they specify some maximum period, such as 26 weeks. Second, if this would produce a shorter period, they either limit (1) the maximum dollar pay-out to some fraction, such as ⅓ or a fraction that declines as the earnings increase, of the base-period wages or (2) the maximum number of weeks to some fraction, such as ¾, of the number of weeks of employment in the base period. Forty jurisdictions have a maximum duration of 26 weeks; 10 have a longer potential duration, 39 weeks being the highest value. Eight jurisdictions provide for extended benefits, usually by 50 per cent up to a maximum of 13 weeks, when unemployment in the state reaches a specified level.

Some states impose special requirements on seasonal workers. For example, wage credits earned in seasonal employment may be counted only in connection with unemployment during the operating season.

Financing. In all but three states employers pay the entire cost of the program. In almost one-half of the states the taxable wage base is higher than the $3,000 federal base and in a few cases is tied to the state average wage. Most states have a maximum tax rate of 2.7 per cent, but in all states the rates paid by employers depend upon their experience and the status of the state unemployment trust fund. Minimum tax rates are usually 0.1 to 0.4 per cent, but in several states they can be zero. Some states have substantial accounts in the Unemployment Trust Fund; others have less than the maximum amount they have paid in a 12-month period.

Issues. Only a few of the important issues can be discussed. First, the heterogeneity of the state plans has disturbed many observers. The most radical solution proposed is a federal program to replace the state programs. A less radical approach would impose federal standards on the benefit formula and other features of the state laws. Most states, however, oppose this exten-

sion of federal authority. It has also been suggested that the federal government serve as a reinsurer of the state programs, thus making it possible to distribute the excess costs nationally when a state experiences unemployment in excess of some specified level. A related suggestion would have the federal government finance the benefits when they extend beyond some specified number of weeks.

Maximum benefit increases have tended to lag behind increases in the average covered wage, with the result that more persons receive the maximum benefit than was originally intended. Relating the maximum duration to earnings during the base period causes some low-income workers, particularly those with a sporadic employment career, to exhaust their benefits at a relatively early stage. Critics press for increases in the maximum benefit and the substitution of uniform durations for the more common variable durations. They would also distinguish more between the low-income breadwinner who becomes unemployed and the low-income secondary wage earner, such as a working wife, who becomes unemployed with the same earnings record. Finally they would use a more nearly current earnings record to determine a worker's eligibility and benefit.

The $3,000 federal wage base and correspondingly low base in most states have been attacked in that they necessitate a higher tax rate, thus placing a heavier tax burden on low-income workers and industries with low-paid workers. Furthermore, there is less opportunity to collect more funds in good times and less funds collected in bad times. Experience rating has been supported on the grounds that it assesses the cost equitably among employers and encourages measures to stabilize employment. It has been criticized because much unemployment is beyond the control of the individual employer, the formulas in use ignore the credibility of the employer's experience,[4] and some employers adopt undesirable hiring and firing practices to reduce their unemployment-compensation rates.

WORKMEN'S COMPENSATION

The purpose and general nature of workmen's-compensation programs, which, except for a few federal programs covering special groups, are state programs, were discussed in Chapter 15.

Issues Other Than Methods of Insurance

Despite the fact that workmen's compensation has existed since the early part of this century, it is subject to frequent attacks. Management often claims

[4] See pp. 420–421.

that industrial commissions are too liberal in their interpretation of occupationally caused injuries and occupational diseases; labor claims the opposite. Some observers argue that the difficulties inherent in these interpretations would be eliminated by replacing workmen's compensation with a program covering both occupational and nonoccupational illnesses. Critics claim that more workers should be covered under the program, there is still too much litigation, benefits are not paid as promptly as they should be, maximum weekly benefits have not increased as rapidly as average weekly wages, the goal of rehabilitation has received too little attention, and state programs vary greatly with respect to some major characteristics (e.g., whether a totally and permanently disabled person will receive benefits for life). Because workmen's compensation is overshadowed by OASDI, the critics believe that it receives little attention from the public and the state legislatures and that for this reason improvements will come slowly. Although agreeing with the direction of many of these criticisms, supporters believe that the deficiencies of present programs have been overemphasized. They believe that there have been substantial improvements in the programs since their introduction and that more can be expected in the future.

Methods of Insurance

One issue of particular interest in this text is the method of insuring the workmen's-compensation obligation. In 44 of the 50 states insurance of workmen's compensation is provided by private insurers of the types discussed in Chapter 24. In 12 of these states insurance is also provided by *state funds*, i.e., insurers operated by the state, it being optional for a private employer to insure either with a private insurer or with the fund. In eight of these 12 states some or all public employers are required to insure with the fund. In six states the state fund is the exclusive means of insurance, and in only two of these may the employer "self-insure," an option which is available in all but one of the other 44 states. In order to self-insure, however, the employer must receive specific permission from the industrial commission or other administering agency. Such permission is usually conditioned upon proof of the employer's financial ability. In many states a deposit of some sort is required. A few employers elect to retain this obligation but, because they are generally large employers, they pay about 13 per cent of the claims.

State funds are a subject of much controversy, ranging from the broad question whether such institutions should exist to the practical performance of individual funds. Proponents of the exclusive fund argue that the state should have full control of the administration of workmen's compensation in order that the interest of the workman may be fully protected; that a single

fund makes for economy by eliminating expenses of competition; and that it is contrary to the spirit of workmen's compensation to permit it to be made a subject of private profit. Against the exclusive fund are brought the arguments that it is contrary to the American principle of private enterprise; that it is subject to political influence in appointments and operation; that its economy is illusory because of hidden subsidies, the general inefficiency of public administration, and failure to render as high-grade service as do private insurers.

Proponents of competitive funds support them by arguing that employers who are required to insure should not be forced to patronize a private insurer; that the state should offer insurance that will serve as a yardstick to measure the performance of private insurers; and that employers who are unable to obtain insurance with private insurers should have access to a public source of coverage rather than be forced out of business. Opponents argue, but less vehemently than in the case of the exclusive fund, that even the competitive fund is contrary to the American way; that it is unnecessary since private insurers are available and since, through assigned-risk plans,[5] they provide for insurance of the unwanted risk; and that private business operation is more efficient than public business operation. As between each competitive fund and its competitors, there are additional arguments concerned with cost, service, methods of competition, and the competitive advantages enjoyed by some funds.

COMPULSORY TEMPORARY DISABILITY INSURANCE

Except in 10 states, a worker who is unable to work because of illness is ineligible for unemployment-insurance benefits. Four states—Rhode Island, New Jersey, California, and New York—enacted laws between 1942 and 1949 that provide benefits for workers who are temporarily disabled because of an accidental injury or sickness incurred *off the job.*[6] These laws complement the protection provided by workmen's compensation and unemployment compensation.

Rhode Island, California, and New Jersey patterned their plans after their unemployment-compensation program because they considered temporary-disability insurance to be an extension of this program and because employee taxes paid in these states for unemployment insurance could be diverted toward this purpose. For the same reasons, their unemployment-insurance agencies administer their programs. The federal government plays no role in

[5] See pp. 467–469.

[6] Three of the state laws also pay benefits if the disability is job-connected, but workmen's-compensation benefits usually reduce the amount otherwise payable.

temporary-disability programs, but a 1946 amendment to the Social Security Act did permit states that had required employees to contribute to the cost of their unemployment-compensation programs to withdraw these contributions for the payment of disability benefits. Nine states could have benefited by this provision. The three states mentioned above took advantage of this change.

New York preferred to relate its program to workmen's compensation because New Yorkers believed that it was appropriate to join together two disability programs. Their Workmen's Compensation Board administers their plan.

A Washington law enacted in 1949 was defeated in a public referendum in 1950. No other state has enacted similar legislation.

Coverage

Interstate railroad workers, government employees, and some employees of some nonprofit institutions are excluded under all four laws. Domestic workers, employers, self-employed persons, and agricultural workers are excluded in three of the four states, but not necessarily the same three states. New Jersey also excludes employers who do not employ four or more workers in each of 20 weeks in a calendar year.

Eligibility for Benefits

To be eligible for benefits, a worker must first demonstrate his attachment to the labor force by having earned a certain amount or worked a specified number of weeks in a prior period. If he has been unemployed for more than a few weeks, he must also prove that this attachment is a continuing one. He must be unable to perform his regular or customary work, but the unemployed worker may be required to meet a stiffer test of disability. He must not be receiving unemployment-compensation benefits. Other income may disqualify or reduce his benefits.

Benefits

All states have a waiting period of 7 consecutive days before the worker can collect any benefits. The disability-income benefit amount depends upon earnings in some prior period; Rhode Island also pays $3 per dependent. The maximum benefit is $80 in California, $62 in New Jersey, $55 in New York,

and 50 per cent of the state average weekly wage in Rhode Island (which in 1967 produced a maximum of $50) plus dependents' benefits up to $12. Benefit duration in all states except New York is related to base-period wages; New York has a uniform potential benefit period of 26 weeks, which is the maximum potential variable period in the other states.

California also provides hospital benefits of $12 a day or 20 days in any benefit period. Hospitalized patients do not have to wait one week for these benefits or for their income benefits.

Insuring Agency

In Rhode Island all benefits are provided through a monopolistic state fund. In California and New Jersey all employers are insured under a competitive state fund unless they apply for and secure approval of a privately insured plan or a self-insured plan. In California a private plan (insured or self-insured) must provide more liberal benefits than the state plan in at least one respect and be at least as liberal in all other respects. Private insurers are also prevented from selecting only those groups whose age, sex, and wage composition might create adverse selection against the state plan. New Jersey requires that a private plan be at least as liberal as the state plan. New York requires that the employer insure through a competitive state fund or a private insurer unless he obtains permission to self-insure this program. New York permits a private plan that provides temporary-disability-income benefits somewhat below the statutory benefits if it provides other types of benefits, such as medical-expense benefits, to make up the difference. Private plans insure less than 10 per cent of the covered employees in California, about half in New Jersey, and over 90 per cent in New York.

Financing

Employees pay the entire cost of the state plan in Rhode Island (1 per cent of the first $4,800 in wages) and California (1 per cent of the first $7,400). The New Jersey state plan is supported by employees (0.5 per cent of the first $3,600 of wages) and employers (0.25 per cent), but the employers' contributions are experience-rated. In New York employees may be asked to contribute up to 0.5 per cent of their first $60 weekly earnings with employers paying the excess. Private plans in the three states permitting these plans may cost more or less than the state plan and the employer may pay for all of these benefits.

Issues

The spread of private employee-benefit plans providing incomes for workers who are temporarily disabled has diminished the interest in these programs, but state legislatures still debate the advisability of this form of social insurance. Some persons would favor including a benefit of this sort under OASDI; some believe that OASDI should through a comprehensive temporary-disability-insurance program replace both compulsory temporary-disability insurance and workmen's compensation. Eligibility requirements and benefit levels are frequently debated, but the most critical issue in existing programs has been the place of private insurance. The questions are similar to those considered in the preceding section with regard to workmen's compensation, but the problem of adverse selection has received much more attention.

PUBLIC-ASSISTANCE PROGRAMS

Despite the comprehensive coverage under social-insurance programs, millions of persons receive benefits under public-assistance programs because their private resources are inadequate to meet their needs and they are either not covered under the social-insurance program or they are receiving small benefits. Table 36–1 on page 576 presents data on the programs to be discussed in this chapter. The discussion will be brief because this text emphasizes the insurance technique.

State Programs Supported by Federal Grants

Under the Social Security Act the federal government makes grants-in-aid to specified state public-assistance programs meeting certain minimum standards. The detailed provisions and administration of the programs are the responsibility of state and local governments.

Old-age Assistance. If a state program providing money payments to the needy aged meets the federal standards,[7] the federal government pays (1) one-half of the reasonable administrative expenses of the state program, (2) 75

[7] Most of the standards deal with administrative matters such as requiring the state to administer the program itself or to supervise local units, protecting the confidentiality of the benefit rolls, requiring the hiring and firing of personnel on a merit basis, and providing for appeals by recipients. In addition, the minimum-age requirement for benefits must not exceed 65 (but the federal government will not contribute to the cost of benefits for persons less than 65 years old), the claimant cannot be required to live in the state more than 5 out of the preceding 9 years and 1 year immediately preceding his application, any citizen should be eligible, and benefits must be based on need (but need is not defined, and some earnings can be disregarded).

per cent of the cost of providing certain "social services" designed to help persons attain or retain some ability for self-care or self-support, and (3) the following portion of the average monthly pension per aged person:

$3\frac{1}{37}$ of the first $37, plus
50 to 65 per cent of the next $38.

For states with per-capita incomes equal to or in excess of the national average, the second fraction is 50 per cent. States with below-average per-capita incomes receive a larger percentage depending upon how much their per-capita income is below the national average. The purpose of this "equalization" procedure is to help the poorer states to improve their benefits.

All states have such programs. Usually they require that the recipient be at least age 65, consider a person to be needy if he has insufficient income or other resources to provide reasonable subsistence compatible with decency and health, and set definite limits on the amount of property that an applicant may own if he is to qualify for benefits. The amount of assistance is determined by subtracting from the claimant's personal requirements (based on state standards adapted to his individual situation) his other resources.

In many states Old-age Assistance has been combined, as permitted under the federal law, with Aid to the Blind and Aid to the Permanently and Totally Disabled.

Aid to the Blind. The federal grants to state programs providing aid to needy blind people are calculated in the same way as federal grants for Old-age Assistance. All states have such programs; most impose no age requirement.

Aid to the Permanently and Totally Disabled. All states except Nevada have federally supported programs providing aid to the needy permanently and totally disabled. These plans are, on balance, slightly less liberal than Aid to the Blind. The federal-grant formula is the same as for Old-age Assistance.

Aid to Families with Dependent Children. If the state has an approved program providing benefits to needy families, the federal government will pay (1) 50 per cent of the reasonable administrative expenses, (2) 75 per cent of the cost of certain "social services," and (3) the following portion of the average monthly benefit per recipient (not family):

⅝ of the first $18, plus
50 to 65 per cent of the next $14.

The fraction in the 50 to 65 per cent range depends upon the state per capita income relative to the national average. Federal aid, however, is limited to those programs providing assistance in cases (1) where the father has died, become mentally or physically disabled, or is continually absent from the home because of a divorce or desertion on his part or (2) where the parents are unemployed. Rehabilitation services of various sorts are an important part of this program. All states have such programs but many do not provide any payments where the parents are unemployed.

Medical Assistance. Under Title XIX of the Social Security Act, popularly known as Medicaid, the federal government pays (1) half of the administration costs and (2) 50 to 83 per cent of the payments made under state programs to vendors of medical care (e.g., doctors and hospitals) for a broad range of services to needy persons or the medically indigent (persons who are needy only with respect to medical expenses). The fraction depends upon the relationship between the state and national per capita incomes, the poorer states receiving the larger percentage grants. For the present, state programs can be limited to the types of needy persons eligible under the four categorical programs described above, but the federal government will contribute to the cost of benefits for the medically indigent in these categories, as well as the indigent, and will in addition support the cost of benefits to all needy children.

At present some states make vendor payments under five other federally supported public-assistance programs (the four categorical programs plus a special plan for the medically indigent aged), but by 1970 these states must have replaced these arrangements with a Medicaid program or lose federal support for these other vendor payments. To receive federal funds, the states must also demonstrate that they are making efforts to broaden the services and liberalize the eligibility requirements so that by 1975 all indigent or medically indigent persons, not just those under the four categorical programs, receive comprehensive care and services.

Issues. Public-assistance programs have been criticized on the grounds that they do not attack the reasons why people are needy and, indeed, that they perpetuate need. Many recipients, it is argued, prefer relief to work. Others do not make advance preparation for contingencies, such as death, disability, or old-age, because they know they can turn to some public-assistance program. Aid to Families with Dependent Children has been subject to more criticism than the others because, it is argued, it encourages illegitimate children and desertion by the father. This school of thought was principally

responsible for certain changes introduced in this program by the Social Security law amendments of 1967. Starting July 1, 1969, all states desiring federal financial assistance must establish work- and job-training projects to which they are expected to refer most able-bodied adult recipients. As an incentive to the recipient to accept work-training experience, the state must pay him a monthly allowance. In order to encourage employment, the state must disregard some portion of a worker's earnings in determining his assistance payment. Recipients refusing to accept work or training without due cause are to be denied further assistance; payments on behalf of the children, however, must be continued in a way that will protect their interests.

Although admitting that some families do react in unfortunate ways, supporters of public-assistance programs argue that most recipents merit the meager assistance they receive. They also point to the increasing emphasis on social services, protective payments, and the like, under these programs.

Persons who support the basic principles of public assistance may nevertheless argue for tightening or liberalizing the eligibility requirements or the benefit structure. Some liberals argue that the administration of the system should be made more objective in order to reduce the degree of prying into the recipient's personal affairs. Liberals and conservatives alike have criticized the complexity of the administrative framework.

The heterogeneity of the state programs with respect to eligibility requirements and, particularly, to benefit amounts relative to needs is disturbing to most observers. More detailed and comprehensive federal standards have been suggested as one solution that would retain the states' dominant role in the program. Unfortunately, states vary greatly in their financial capacity to support an adequate program.

The categorical approach in the federal-state programs excludes many poor persons. This is one reason why the Poor People's March on Washington, D.C., in the summer of 1968 sought a guaranteed minimum-income program of the sort explained on pp. 579–580 as a substitute for the present public-assistance programs. The Title XIX medical-expense programs are supposed to be gradually extended to cover all the indigent and the medically indigent.[8]

General Assistance

Needy persons who are not eligible for aid under the federal-state programs must turn to general assistance programs financed entirely by state and local

[8] A few states set the qualifying income level in the programs they established in 1965 and 1966 so high that Congress in 1967 decided to limit federal participation to benefits paid to families earning less than one and one-third times the payment level under Aid to Families with Dependent Children.

governments.[9] Payments are made in cash or in services. All but three states have such programs. Eligibility requirements tend to be much more severe and benefits much less adequate than under the federal-state programs.

Prior to the Social Security Act of 1935, general assistance was the major program in the United States economic-security system. As the social-insurance and federal-state public-assistance programs have been extended and liberalized, the role of general assistance has been drastically reduced, but it still is an important program for many families.

QUESTIONS

1 A worker, aged 65, retires in 1971. He earned $10,000 annually in OASDI-covered employment during the 5-year period from 1966 through 1970.
   - **a** Is this worker fully insured?
   - **b** Is he currently insured?
   - **c** What is his primary insurance amount?
   - **d** If he has a wife, aged 65, what retirement benefit will he and his wife receive?

2 A worker, aged 35 in 1969, has a wife, aged 32, and a son, aged 5. He is fully insured under OASDI and has average monthly earnings of $500. What benefits will be paid under OASDI if
   - **a** he dies in 1969?
   - **b** he becomes totally and permanently disabled in 1969?

3 Is OASDI actuarially solvent?

4 "OASDI stresses social adequacy more than private equity." Discuss the truth or falsity of this statement.

5 Deductibles and private-public administration are important features of Hospital Insurance and Supplementary Medical Insurance. Explain.

6 What changes would you favor in OASDHI?

7
   - **a** What role does the federal government play in unemployment compensation?
   - **b** What role do you believe the federal government should play?

8 Evaluate the method of determining unemployment-compensation benefits.

[9] The reader is reminded that such persons may also participate in the various programs established under the Economic Opportunity Act of 1964, but these programs are not public-assistance programs. The United States Department of Agriculture also sponsors a food-stamp program for needy persons that enables them to purchase certain food products at prices lower than retail.

9 Evaluate the role of state funds in workmen's compensation insurance and in compulsory temporary-disability insurance.
10 How does the federal government attempt to reduce the heterogeneity among public-assistance plans?
11 Compare Title XIX medical-assistance programs with Hospital Insurance and Supplementary Medical Insurance.
12 Why do general-assistance programs still exist? Will they always exist?

38
OTHER GOVERNMENT INSURANCE PROGRAMS

Some important government insurance programs are not part of the social-security system as defined in this text. This brief chapter deals with the most important of these programs.

INSURANCE ON DEPOSITS

Background

In the 1820's the circulating medium was about equally divided between bank deposits and currency, and practically all the currency, other than minor coins, consisted of the circulating notes of commercial banks. As a result of a considerable number of bank failures in the early 1820's, four states set up insurance funds covering both notes and deposits or provided for mutual guarantee of bank obligations. One of these funds was modified to cover notes only, and by 1858 two additional states had set up plans covering notes only. By 1866 these funds had ceased operation because of failure (Michigan), expiration of charters of participating banks (New York and Vermont), or conversion of participating banks to national banks (Indiana, Iowa, and Ohio). From 1907 to 1917 eight other states established deposit guarantee funds. For varying reasons none of these plans were in operation in 1933, when the large number of bank failures and the high failure rate of larger banks in the late 1920's and early 1930's had created a tense situation.[1]

[1] For an illuminating discussion of the history of these eight funds see *Annual Report of the Federal Deposit Insurance Corporation for the Year Ended December 31, 1956*, Part 3.

Federal Deposit Insurance Corporation

The Banking Act of 1933 provided for both temporary and permanent insurance of bank deposits through the *Federal Deposit Insurance Corporation.* The temporary plan, which was originally intended to have been of but 6 months' duration, was kept in effect until August, 1935. The Banking Act of 1935 revised and put into effect the permanent plan.

The Corporation now protects depositors against loss due to bank failure to the extent of $15,000 ($2,500 in 1933) per depositor "in the same right and capacity" in each insured bank. Deposits of public funds by a representative of a governmental unit are accorded the same protection. At the close of 1966, nearly 99 per cent of all deposit accounts in insured banks were of $15,000 or less, though accounts of more than $15,000 represented almost one-half of the total deposits.[2]

The activities of the Corporation in exercising supervisory control over all insured banks and correcting unsafe or unsound practices serve to maintain solvency and therefore to protect depositors against losses in excess of $15,000. If a bank continues to engage in such practices or in violation of law or regulations, insurance of its deposits may be terminated. If an insured bank fails, the Corporation may either pay each depositor up to the insurance maximum or arrange for assumption of the bank's deposit liabilities by another insured bank. Under the first method recovery of balances in excess of the maximum is dependent upon dividends paid by the receiver; full recovery had not been received as of December 31, 1966, by 2.4 per cent of the depositors where this method was used, but over two-thirds of these depositors might still recover their money because their case was still active. These depositors controlled 11.1 per cent of the deposit amounts in these banks, but over 90 per cent of these deposits involved cases that were still active.[3] Under the second method, all depositors receive full recovery of their deposits.

National banks and state banks of deposit admitted to the Federal Reserve System are automatically insured. Other eligible banks are insured on application and meeting the requirements of the Corporation. At the end of 1966 there were 13,873 insured banks, about 97 per cent of the banks of deposit in the United States.

Insured banks are assessed $\frac{1}{12}$ per cent per annum of total deposits, payable semiannually. During recent years, because of favorable experience, credits against assessments have resulted in an effective assessment of about $\frac{1}{31}$ per cent.

The Corporation had built up a deposit insurance fund of over $3 billion (about 1.8 per cent of the insured deposits) by the end of 1966 and repaid

[2] *Annual Report of the Federal Deposit Insurance Corporation, 1966,* p. 5.
[3] *Ibid.,* p. 12.

with interest the capital originally advanced by the Treasury and the Federal Reserve banks. During its entire history (1934 to 1966) the Corporation made disbursements to protect depositors in 466 banks, 276 of which were placed in receivership and the depositors paid direct by the Corporation and 190 of which were absorbed by other insured banks after the Corporation made disbursements to facilitate the assumption of their deposits. Total disbursements by the Corporation over this period were about $421 billion, of which the Corporation had recovered or expected to recover over $373 billion from the assets it acquired or the claims of depositors whose claims it had paid. During 1966, however, the Corporation disbursed $15 million to protect the depositors of seven banks, the largest sum it had expended since 1941.[4]

Federal Savings and Loan Insurance Corporation

The Federal Savings and Loan Insurance Corporation was created in 1934 to perform the same general functions for savings and loan associations as are performed by the Federal Deposit Insurance Corporation for banks. It insures savers in these institutions against loss up to $15,000 per saver. Few savers have accounts larger than $15,000.

Like the FDIC, the FSLIC may either pay the saver his insured claim or it may arrange for a merger or a transfer of the failing association's assets and liability to some other institution. In 32 years of operation up to the end of 1966, the Corporation had made payments in only 10 cases. In 1966 alone it arranged for seven mergers or transfers.[5]

All federal savings and loan associations must be insured by the Corporation. State-chartered associations may be insured if they are members of the Federal Home Loan Bank System. At the close of 1966 the 4,510 insured associations included 2,051 federal institutions and 2,459 state associations. Almost 500 state associations that were members of the Federal Home Loan Bank System did not purchase insurance.[6]

Members are assessed at the annual rate of $\frac{1}{12}$ per cent of all savings plus creditor obligations. By the close of 1966 the Corporation's reserves amounted to about $267 million (about 1.53 per cent of the total amount of all insured savings accounts and creditor obligations).[7]

[4] *Ibid.*, pp. 31, 12–13.
[5] *34th Annual Report of the Federal Home Loan Bank Board For the Year Ending December 31, 1966*, pp. 66–67.
[6] *Ibid.*, p. 61.
[7] *Ibid.*, p. 59.

State Deposit Insurance

In Massachusetts all deposits in mutual savings banks or in cooperative banks (savings and loan associations) are required to be insured in full by central funds created by state statute. Since 1958 the banks have become members, respectively, of the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation, in which case the state-fund insurance covers deposits in excess of the $15,000 insured by the federal corporation. Similar voluntary arrangements exist for mutual savings banks in Connecticut and for building and loan associations in Ohio.

CROP INSURANCE

Federal Crop Insurance Corporation

The Federal Crop Insurance Corporation is a federal insurer providing all-risks crop insurance against unavoidable natural causes of loss. Established by the Federal Crop Insurance Act of 1938, the Corporation at first insured only wheat, but it now covers many agricultural commodities. The perils covered are all natural perils, including such causes of loss as drought, excessive moisture, wildlife, insect infestation, plant disease, flood, hail, wind, earthquake, frost, freeze, winter-kill, lightning, fire, excessive rain, snow, hurricane, and tornadoes. The guaranty for most crops is a certain number of bushels or pounds of good quality per acre. The price-per-bushel limit selected by the farmer determines his recovery and his premium. The operation is supported by these premiums and by an annual congressional appropriation equal to about two-thirds of the operating and loss-adjustment expense. Most contracts are sold by Corporation employees, but in a few states the contracts are sold by commissioned agents.

The Corporation's experience in its early years was so unfavorable that Congress in 1943 ordered the program liquidated. However, in 1944 the program was reinstated on a modified basis. In 1947 Congress placed the entire program on an experimental basis by restricting the number of commodities that could be insured and the number of counties in which the insurance was available. Attempts were made to secure a better distribution of risk, to develop rates that more adequately reflected the variation of expected losses among crops and counties, and to service and sell the contracts more effectively. Prior to these changes, the total benefits far exceeded the premiums paid, but since that time the aggregate premiums received have exceeded slightly the aggregate benefits paid. In some years (1949 and 1954, for

example) the loss ratio has been considerably higher than 100 per cent; in other years (1958) it has been as low as 26 per cent. Consequently Congress has gradually permitted the Corporation to expand its activities to include more crops and more counties. In 1964 the Corporation collected over $34 million in premiums and paid out about $30 million in losses. Administrative and operating expenses were about $12 million. It had working capital of almost $44 million. The insurance was available in almost 2,700 counties in 36 states.[6]

State. State crop-insurance plans have been confined to insurance against loss by hail. Colorado and Montana are the only states that still have plans. North Dakota, which had the largest plan, terminated its operation at the close of 1967. Nevertheless, because of its historical importance, the North Dakota plan will be described briefly.

In 1911, North Dakota set up a state hail-insurance fund. Insurance in the fund was optional. The rates fixed by law proved to be inadequate, so that losses could not be paid in full, and the fund was unsuccessful. In 1919, a new law was enacted providing for a semicompulsory state hail fund which had some unfortunate years but wrote about 90 per cent of the hail insurance in the state. Under the 1919 law the tax rate for hail insurance was uniform throughout the state but was inequitable, since the risk was far from uniform. In 1923, the law was amended to provide for districting the state and setting the rate for each district according to the hazard. In 1931, the law was again amended to make it necessary for the farmer to elect insurance, rather than be automatically insured unless he declined before a set date. The assessor of each district was, however, required when making his general tax assessment to explain the operation of the hail-insurance law and to take the application for insurance if desired. The farmer who had not applied through the assessor could apply through the county auditor or direct to the fund.

The fund was operated by a manager under supervision of the insurance commissioner. On the occurrence of hail damage, the loss was adjusted by representatives of the fund, and a warrant issued on the state treasurer. The loss payment was based upon the percentage of damage to the crop, subject to a maximum payment of $20 per acre. Farmers paid for this insurance through an "indemnity tax" which was payable in the same manner as other taxes at the next tax period.

The peak year for the fund was 1951, when it insured over four million acres. The coverage dropped substantially after 1962, when the state legis-

[6] Information on the operation of the Corporation can be found in the annual hearings before a subcommittee of the Committee on Appropriations of the House of Representatives on the Department of Agriculture Appropriations.

lature required the fund to pay less than the amount otherwise allowed in those counties with unsatisfactory loss experience. This limitation was removed in 1965, but the fund's business continued to decline in 1966. Premium volume increased again in 1967, but the 1967 legislature abolished the hail insurance department.

FLOOD INSURANCE

The risk associated with flood losses to real property lacks many of the characteristics of an ideally insurable risk outlined on p. 66. Many persons are exposed to this loss, but a large proportion of these persons may suffer loss from a single event. Because most people with a serious interest in flood insurance have a high loss potential, the premium that would have to be quoted by a private insurer would be so large relative to the property value insured that the insurance would not be economically feasible. Consequently, private insurers have been reluctant to write flood insurance on real property except in rare cases. Flood insurance on personal property is readily available because this property is usually mobile.

Flood disasters, however, have created many hardships for the persons directly affected and for society. Loss-prevention-and-reduction measures need to be explored more fully, but a complementary alleviative program has been needed for some time. In 1956, following some serious flood losses in the northeastern United States in 1954, the Congress enacted a flood-insurance program to be financed and administered by the federal government with some participation by private insurers. Because Congress later became unhappy about certain portions of the law, they never appropriated any funds for the program.

Congress, however, continued its interest in some type of national flood-insurance program and, following extensive research and debate, passed the National Flood Insurance Act of 1968. Under this Act the Secretary of Housing and Urban Development is authorized to establish a program that will enable interested persons to purchase flood insurance on real or personal property located in states that have adopted satisfactory land-control and -use measures. Without this land-use restriction it was feared that the program would provide too much incentive for some people to build or to continue living or operating in areas that are highly susceptible to flood damage. Priority is to be given to residential properties designed for one- to four-family occupancy and to small commercial properties. Protection up to $17,500 per dwelling unit and $30,000 per multiple-dwelling unit, $5,000 for contents per dwelling unit, $30,000 for other single structures, and $5,000 for contents per business unit in a single structure is to be made

available at "chargeable" premium rates that will be less than the estimated losses and expenses in order to encourage the purchase of this insurance. The Secretary is to determine both the chargeable premiums and the "true" expected costs. The face amount of flood insurance in force at any one time is not to exceed $2.5 billion.

An advisory committee, including representatives of private insurers, state and local governments, lending institutions, home builders, and the general public, will advise the Secretary in the preparation of regulations, on policy matters, and in any other way he may deem advisable.

Private insurers will market and service the insurance, which will be underwritten by a pool created by those private insurers who wish to participate in the program as risk bearers as well as fiscal agents. The federal government will contribute the difference between the chargeable premiums and the premiums that would be required on a nonsubsidized basis. In addition, a National Flood Insurance Fund will, in return for a premium paid by the pool, reimburse the private pool for losses in excess of a specific amount. Thus the government's role in this program includes establishing the chargeable premiums, paying the subsidy necessary to meet expected costs, and reinsuring the private pool. The possibility of extending this concept of a joint private-public venture to other unusual perils such as earthquake is already under consideration.[9]

INSURANCE AGAINST CIVIL DISORDERS

The National Insurance Development Fund, which reinsures private insurers against the risk of catastrophic loss from civil disorders, was established in 1968 under a separate title of the Housing and Urban Development Act of 1968, the same legislation that created the flood-insurance program. This Fund was originally suggested by the President's National Advisory Panel on Insurance in Riot-Affected Areas, whose other recommendations were discussed on pp. 468–469. Like the flood-insurance program, the Fund is administered by the Secretary of Housing and Urban Development.

Only insurers participating in the FAIR plans and their joint reinsurance associations described on pp. 469 are eligible to purchase reinsurance from the Fund. Furthermore, the state in which the insured property is located must agree to reimburse the Fund, up to some limit, for reinsured losses in excess of the fund accumulated out of reinsurance premiums paid by the state's participating insurers. The Fund has borrowing authority to

[9] Medicare, consisting of the hospital and supplementary medical expense insurance programs for the aged, is based on a somewhat different concept because the private insurers are not risk bearers under that program.

provide monies needed to pay losses in excess of accumulated reinsurance premiums and the state "financial backup." In case of a serious loss, therefore, the private insurers would first bear their retained losses. The first layer of reinsured losses would be paid by the Fund out of accumulated reinsurance premiums, the second layer by the state, and the third layer by the Fund with borrowed monies which it will recover out of future reinsurance premiums.

MISCELLANEOUS INSURANCE PROGRAMS

Title Insurance

Several states have enacted "Torrens" title laws, under which the state may grant an indefeasible title to land. Application for such a title is made to the court, which orders registration of the title, if after examination it appears to be justified. This registration, as of its effective date, relieves the owner of any responsibility for satisfaction of claims against the property based on previous happenings. A fee is charged to cover the expenses of registration and a contribution to a state (or county) insurance fund from which claimants whose claims against the property (antedating the registration) would be frustrated might be compensated. Some states have county Torrens title funds.

While many Torrens laws have been adopted, their use has been extremely limited in most states, though considerable use has been made of the Massachusetts Land Court, which is that state's version of the Torrens system.

Loan Insurance

The federal government engages in insurance or guarantee of loans made for the following purposes: property improvement; purchase of new and other houses of not over four-family capacity; construction (including major rehabilitation) of rental housing; construction of cooperative housing for transfer to members or for occupancy by members of, and acquisition of housing projects by, cooperatives; purchase of permanent houses sold by the government, primarily defense and war housing; provision of sites for trailer courts; construction, reconstruction, or reconditioning of certain types of vessel; and veterans' house, farm, and business financing.

The insured in each case is the lender. The conditions under which loans are made must conform to governmental requirements, and only such loans are insured as meet the underwriting standards of the government.

War Risk Insurance

The federal government has provided for the insurance of water-borne and air-borne commerce against loss due to war perils on a stand-by basis, i.e., such insurance will be available when it cannot be obtained from private insurers. The Maritime Administration is currently issuing war-risk marine-insurance binders, which become effective during time of war after private insurance is canceled.

War damage insurance was provided for coverage of private property during the Second World War by the War Damage Corporation, a governmental instrumentality, and was sold to insureds through the facilities of private insurers, which assumed a 10 per cent interest in the underwriting profit or loss of the corporation. Losses incurred were nominal.

Public Property Insurance Funds

A few states have established self-insurance funds for the insurance of public property against loss due to fire, lightning, windstorm, and similar perils. Some of these funds cover only state property; others cover property of lesser units as well. When the fund covers only state property, it is not insurance, because there is no transfer to an outside agency; but when lesser units are involved, the fund can be viewed as a cooperative insurer. Because their exposure units were limited in number and geographical distribution, some funds have experienced unfortunate losses.[10] Some municipalities and counties also maintain self-insurance funds.

Some Other Programs

The Export-Import Bank of Washington provides protection on exports against certain political losses such as inconvertibility of foreign currencies. The Atomic Energy Commission underwrites nuclear energy liability insurance in excess of that available from private sources. The state of Wisconsin has sold low-cost life-insurance policies to its residents since 1911 through a state life-insurance fund operated by the state insurance commissioner.

These brief summaries of federal, state, and local insurance activities are intended merely to indicate the nature and variety of such programs. Further information is available in the reports of the governmental bodies administering the various programs.

[10] "At Your Own Risk."

QUESTIONS

1 Should a deposit-insurance plan concern itself solely with the payment of indemnity to depositors?
2 Is the contract issued by the Federal Crop Insurance Corporation an all-risks contract?
3 Why was it necessary to create a federal flood-insurance program?
4 What difference is there between the protection furnished by private title insurers and that furnished under Torrens laws?
5 Which of the government insurance programs described in this chapter compete with private insurers?
6 What role has the federal government assumed with respect to insurance against riot losses?

39
PROTECTING THE MOTOR-TRAFFIC VICTIM

Public attention has been increasingly focused in recent years on the status and problems of the motor-traffic victim. This chapter deals with the reasons for this interest and some of the measures that have been adopted or proposed to ease the plight of the person injured in a motor-vehicle accident.

THE PROBLEM

Motor-traffic victims may suffer bodily injuries or property damage of various degrees with resultant economic losses. Society has long been interested in the welfare of these victims, but this interest has intensified in recent years because of (1) mounting costs of motor-vehicle accidents and (2) increasing awareness of deficiencies in the reparation systems by means of which the victim can shift at least part of his loss to others.

The Mounting Costs of Motor-vehicle Accidents

The total costs of motor-vehicle accidents are determined by their frequency and their severity. Table 39.1 presents several common measures of the accident frequency for the period 1940 to 1966. Paid claim frequencies understate the injury and damage rates because they include only those injuries and damage that resulted in insurance payments. Nevertheless, these data are the best available measure for measuring highway-accident trends. These frequencies vary greatly among the states, largely because of differences in traffic density. For example, in 1966 the bodily-injury claim frequencies per 100 car-years varied from 7.72 in Massachusetts and 4.22 in New York to 0.90 in North Dakota and 0.80 in Wyoming. Death rates are a much less satisfactory measure of these trends because only a small percentage of accidents result in deaths.

The paid-claim frequencies are disturbingly high. Fortunately the rates

Table 39–1 AUTOMOBILE ACCIDENT FREQUENCIES AS MEASURED BY THREE YARDSTICKS, 1940–1966

Year	Insurance-liability claims per 100 car-years[1]		Deaths per 10,000 vehicles registered
	Bodily injury	Property damage	
1940	*	*	10.63
1945	*	*	9.05
1950	*	*	7.07
1955	*	*	6.12
1959	2.71	8.43	5.26
1960	2.77	8.41	5.12
1961	2.76	8.37	4.98
1962	2.65	8.08	5.12
1963	2.61	7.92	5.22
1964	2.71	8.24	5.46
1965	2.66	8.08	5.36
1966	2.59	7.82	5.52

* Not available.

[1] Number of insurance-liability claims paid in a given year divided by the number of car-years insured in that year. A car-year is one car insured for one year. One car insured for half a year is a ½ car-year.

Sources: Insurance Institute of Highway Safety, "Accident Facts," 1967 ed.; National Safety Council, Chicago, 1967, p. 59.

are not increasing; but because the number of vehicles registered and insured is growing at a rapid pace (about 78 million registered in 1966 compared with about 62 million in 1960), the number of claims is increasing at a disturbing rate. The National Safety Council has estimated that in 1966 there were 13.6 million accidents, about 44 thousand of which caused death as the worst result, 1.2 million caused nonfatal injuries, and 12.4 million caused only property damage. Their estimate for 1960 was 33 thousand fatal accidents, 900,000 nonfatal-injury accidents, and 9.5 million property-damage-only accidents.[1]

Table 39.2 shows how the costs of motor-vehicle accidents have risen since the Second World War as measured by insurers' average paid-claim costs. The increases of over 100 per cent in average bodily-injury-claim costs and of over 150 per cent in average property-damage-claim costs from 1946 to 1966 compare with an increase over the same period in the Consumers' Price Index of under 80 per cent. Wages have risen faster than the cost of living; medical-care and automobile-repair costs have also increased more than the general cost of living, and juries have become more liberal in determining awards.

[1] "Accident Facts," 1967 ed., p. 40. "Accident Facts," 1961 ed., p. 40.

The American Insurance Association estimates that in 1966 the nation's traffic accidents cost over $12 billion in lost income, medical expenses, property losses, legal charges, and the administrative costs of insurance.[2] Only part of this loss was paid by the nation's insurers, a point which is examined in more detail below. The Association estimate for 1960 was about $7.5 billion, indicating an increase of about 70 per cent from 1960 to 1966.

Clearly the social cost of automobile accidents as measured in dollar terms, let alone human suffering, is already staggering. For the victims the results can be catastrophic. Great stress must be placed upon improving driver attitudes and skills, making automobiles safer, building better highways, developing more satisfactory traffic controls, enacting more adequate traffic laws, and enforcing existing laws more effectively. The remainder of this chapter, however, will concentrate on the ways in which the financial losses suffered by motor-vehicle victims can be alleviated.

Reparation Systems

In a recent frequently quoted study by several University of Michigan investigators, there were identified five types of reparation systems by which a person suffering a bodily injury could shift some of his losses to the larger community:[3]

Table 39–2 COUNTRYWIDE AVERAGE PAID-CLAIM COSTS* FOR PRIVATE PASSENGER AUTOMOBILE LIABILITY INSURANCE, 1958–1966

Year	Bodily-injury claims	Property-damage claims
1958	$ 981	$151
1959	1,031	159
1960	1,070	167
1961	1,099	169
1962	1,113	176
1963	1,113	181
1964	1,129	189
1965	1,202	203
1966	1,296	221

* Claim costs include all loss-adjustment expenses. Average paid-claim costs = Claims paid in dollars divided by number of claims paid.
Sources: "Insurance Facts, 1967," Insurance Information Institute, New York, 1967, p. 59.

[2] "Insurance Facts, 1967," p. 58.

[3] A. F. Conard, *et al.*, "Automobile Accident Costs and Payments: Studies in the Economics of Injury Reparation," p. 29.

(1) Legal-liability systems, including the tort system and workmen's compensation
(2) Private loss- (life and health) insurance systems
(3) Sick-leave and employee-benefit plans covering nonoccupational disability
(4) Social insurance
(5) Noninsurance public programs, such as public assistance and veterans' benefits

According to these investigators, the victims of automobile accidents in Michigan in 1958 that involved some personal injuries recovered about $85 million from these five systems.[4] About 55 per cent of the reparation came from the tort-liability system, 38 per cent from the victim's own private loss insurance, and the remaining 7 per cent from the other three sources. About $8 million additional reparation was expected in the future, but the sources were not identified. The estimated economic loss—loss of income and expenses incurred—was $178 million.[5] Consequently, 47 per cent of the losses were not shifted at all. Furthermore, a substantial share of the burden was shifted because of the victim's own efforts in securing private loss insurance. Tort settlements amounted to only 26 per cent of the loss. Only 37 per cent of the approximately 86 thousand persons sustaining economic loss received any tort settlement.[6]

The adequacy of tort settlements has been of particular interest to state legislatures because these settlements potentially shift the losses from those who should not bear them to those who should. Because tort settlements are based upon the law of negligence, they are subject to some of the arguments presented on p. 223 with respect to employers' liability:

1 Correct apportionment of blame is almost impossible. The outcome is too frequently determined by chance, the skill of the victim's lawyer, the composition of the jury, and other extraneous factors. Automobile accidents pose a special problem because the speed with which they occur makes it extremely difficult for witnesses to describe what happened. Drivers and victims are tempted to be dishonest in their description of the accident because of the ease with which this can be done and their economic interests.
2 Recovery is delayed for months or even years because of lengthy investigation periods, court congestion, and appeals. In the Michigan study, 31 per cent of the serious-injury cases were settled within 6 months after the accident, but 22 per cent had to wait for more than 2 years.[7]

[4] *Ibid.*, p. 147.
[5] *Ibid.*, p. 142.
[6] *Ibid.*, p. 149.
[7] *Ibid.*, p. 221.

3 Tort settlements are not net benefits. Instead, the victim usually incurs some collection expenses, such as lawyers' charges, lost wages, and transportation costs. Almost 70 per cent of the serious cases in the Michigan study reported some collection expenses, the average expenses for the group incurring some expense being 32 per cent of the tort settlement. About 4 per cent of the serious-injury cases reported collection expenses of 60 per cent or more of the tort settlement.[8] In addition to the collection expenses borne by the victims, society must maintain an expensive court system.

4 Tort settlements are not related to the economic loss but, like the determination of blame, are affected by many other considerations. On the basis of their analysis of serious cases, the University of Michigan investigators concluded that it "looks as though the amounts of settlement were a random choice, or at least completely unrelated to amount of economic loss."[9] However, when the cases were classified by the amount of economic loss sustained, low rates of settlement were most common in the large-loss cases. Over 80 per cent of the cases with losses under $1,000 received tort settlement equal to more than three-fourths of their loss. Only 23 per cent of those with losses over $5,000 but under $25,000 were this fortunate.

Other criticisms, not leveled against employers' liability, include the following:

5 Courts have become so prone to find negligence in automobile cases that, if current trends continue, few defendants will escape a finding of negligence on their part.

6 Because of the trend in court decisions and the existence of liability insurance, tort law is much less effective than it was formerly as a method for placing the blame on careless drivers and encouraging them to drive more carefully.

7 Pain and suffering allowances, which are highly subjective, account for too large a proportion of the total settlements.

Criticisms such as these have caused some persons to propose that the present negligence system be replaced by a motor-vehicle compensation system similar to workmen's compensation. These proposals are discussed in the concluding section of this chapter. For various reasons to be discussed later, however, none of these proposals have been adopted as yet in the United States. Instead, public action has assumed the continuation of the negligence system and focused upon a much narrower problem—the failure

[8] *Ibid.*, pp. 190–191.
[9] *Ibid.*, p. 194.

of many motor-traffic victims to collect adequate damages from negligent drivers or owners because these negligent parties are financially irresponsible. The discussion now turns to these programs.

PROGRAMS DESIGNED TO ASSURE FINANCIAL RESPONSIBILITY

Laws designed to protect the automobile-accident victim against financially irresponsible drivers fall into three groups: (1) financial-responsibility laws, (2) compulsory automobile liability insurance, and (3) unsatisfied-judgment funds.

Financial-responsibility Laws

Forty-seven states[10] and the District of Columbia have financial-responsibility laws. In general the purpose of these laws is to require proof of financial responsibility only of those who have shown that such proof is needed in order to protect the public. An operator or registrant who has not been involved in an occurrence on account of which proof is required may register and operate his car without giving evidence of financial responsibility.

State laws vary somewhat in details, but the following description of the operation of a typical law indicates the basic approach. First, if a person is convicted of certain offenses such as drunken driving, reckless driving, or speeding, he must prove that he would be financially responsible for motor-vehicle losses he may cause in the next three years up to $10,000 for bodily injuries incurred by one person and $20,000 per accident, and $5,000 per accident for property damage. The proof usually takes the form of an automobile-liability-insurance contract,[11] but cash, certain securities, and surety bonds are also acceptable. Failure to meet this requirement will cause the operator to lose his driver's license and the owner to lose his registration.

Second, on occurrence of an accident involving bodily injury or a stated minimum of property damage, the license of the operator and the registration of any car are suspended unless, or until, evidence of financial responsibility is filed with state authorities covering, up to the limits stated earlier, any damage for which a judgment might later be incurred. Mere involvement in the accident is sufficient to trigger the requirement: the driver need not be the guilty party, the one exception being that in some obvious cases, such as

[10] The four states with unsatisfied-judgment funds and financial-responsibility laws are included in this number.

[11] For the special contract provision covering the strict liability imposed on insurers under these laws and compulsory-automobile-insurance legislation, see p. 260.

a legally parked car being hit by a negligent driver, the innocent driver may be excused. The proof may take the form of an insurance contract, cash, or a surety bond. If such proof is not forthcoming, the requirement is generally terminated only by exoneration of blame for the accident; release by or agreement with, the injured party; or lapse of a year without suit being filed.

In less than half the states, motorists involved in accidents must also furnish proof of future financial responsibility for, say, 3 years. In practically all states, if a judgment is returned against an uninsured motorist, he must satisfy that judgment up to the financial-responsibility-law limits or his license and registration will be suspended until the judgment is satisfied up to those limits and proof of financial responsibility for, say, the next 3 years is provided.

Financial-responsibility laws encourage but do not require motorists to be financially responsible.[12] The laws have been praised for their voluntary approach and the absence of extensive enforcement machinery. They have been criticized because they are only partially effective. Many motor-traffic victims go uncompensated because many automobiles are not insured (about 10 per cent nationally and much larger percentages in some states) and their drivers and owners are not otherwise financially responsible. Some financially irresponsible drivers regain their licenses after 1 year because the victim, realizing that the defendant has no assets, decides not to file a suit.

The uninsured-motorists coverage, described on pp. 261–263, is the insurer's answer to this objection. All but a few of the states with financial-responsibility laws now require that insurers include uninsured-motorists coverage in all automobile-liability-insurance contracts. Most of these states permit the insured to reject this coverage, but he must specifically do so. In addition to providing a source of payment for the innocent victim, this coverage strengthens the operation of the financial-responsibility law because 1 year is much less likely to elapse without a suit being filed. Those who object to this approach argue principally that the insured motorists pay the cost of accidents caused by uninsured motorists.

Unsatisfied-judgment Funds

Four states—Maryland, Michigan, New Jersey, and North Dakota—have unsatisfied-judgment funds supplementing their financial-responsibility laws. These funds serve the same purpose and were in fact the inspiration for private uninsured-motorist coverage, North Dakota having pioneered this

[12] Some states with financial responsibility laws also impound the vehicle or require the owner to store it until the owner or operator meets the requirements of the financial-responsibility law.

concept in 1947. The four funds differ somewhat in details, but basically if the innocent victim of a motor-vehicle accident secures a judgment against a negligent motorist who is unable to pay the judgment, the victim may apply to the state unsatisfied-judgments fund for payment up to the limits of the state's financial-responsibility law. If part of the judgment is recoverable outside the fund, this amount is subtracted from the amount otherwise payable by the fund. The fund must receive notice of the accident and has the right to defend the uninsured motorist if this seems desirable. This state fund is supported by assessments on both insured and uninsured resident-owners of vehicles, but only insured resident-motorists and uninsured non-car owners are eligible for benefits. Once the fund pays the judgment, it becomes subrogated to the victim's claim against the negligent driver. These funds thus aid the innocent victim and strengthen the financial-responsibility law in the same manner as private uninsured-motorists coverage. Uninsured motorists have an additional incentive to purchase insurance, as their assessment approaches the cost of insurance, particularly since they are not protected under the fund.

The laws differ with respect to whether they have any reciprocal relations with other states, whether they include property-damage-liability claims, the minimum amount that must be involved before the loss will be entertained by the fund, whether a small deductible is applied to claims against the fund, whether the fund is willing to settle the claim without the benefit of a court judgment if the unisured motorist consents and agrees to reimburse the fund, whether insured motorists pay their assessments direct or through a levy on insurers, the relative proportion of the costs paid by insured and uninsured owners, and whether the fund is administered solely by the state or by the state and private insurers.[13]

Many persons prefer this approach to private uninsured-motorists coverage because the uninsured motorists share part of the costs. On the other hand, this approach as practiced has been criticized on the grounds that the procedures are too complicated, the coverage is sometimes not as broad as that provided under uninsured-motorists coverage, some funds are in severe financial straits, and uninsured motorists do not pay their fair share of the costs.[14] Some observers object on philosophical grounds to the existence of a state fund where, in their opinion, it is not necessary.

[13] For a brief but comprehensive summary of these details, see Sajjad A. Hashmi "Unsatisfied Judgment Funds." For a more recent book-length treatment, see G. Victor Hallman, "Unsatisfied Judgment Funds."

[14] Professor Hashmi has also argued that uninsured motorists should be protected against other insured motorists. *Ibid.*, pp. 98–99. See also Sajjad A. Hashmi, "The Problem of the Uninsured Motorist: A Proposed Solution."

Compulsory Automobile Insurance

A much discussed question is whether all registrants of motor vehicles or operators of licensed vehicles should be required to provide evidence of minimum financial responsibility as a condition for registering their vehicles or securing their drivers' licenses. Because this evidence would usually take the form of insurance, such a requirement is usually termed compulsory automobile liability insurance.

Many classes of registrants and licensed operators must already provide such evidence. Registrants of public vehicles, such as taxicabs, school buses, and other passenger-carrying buses, must generally demonstrate minimum financial responsibility. Interstate motor-vehicle common carriers are required to have insurance or some other evidence that they will be able to pay claims occasioned by bodily injuries to passengers or others or damage to cargo or other property. Young drivers or registrants must post proof of financial responsibility in Connecticut, Maryland, and Rhode Island.

The emphasis in discussions on compulsory automobile insurance, however, is whether *all* registrants or drivers should be required to give such evidence. Three states—Massachusetts, New York, and North Carolina—have adopted this approach. Owners in these states must give evidence of financial responsibility before they can register their vehicles. Nonowners need not demonstrate similar responsibility to secure their drivers' licenses. The Massachusetts Commissioner of Insurance establishes the common initial premium rates to be charged by all insurers, but in New York insurers establish their own rates subject to possible disapproval by the state insurance department. North Carolina requires all insurers to belong to a single rating bureau and permits no deviations from bureau rates.

The major attraction of compulsory automobile liability insurance is its straightforward approach to this problem. If completely successful, it would allocate the costs more equitably and simplify collections by injured victims. Critics, however, observe that the law is not completely effective. For example, the law does not protect the victim against financially irresponsible drivers from other states, stolen vehicles, hit-and-run drivers, insured owners whose insurers become insolvent, and owners who elect to violate the law. New York, recognizing this fact, requires that all insurance contracts issued under its law include uninsured-motorists coverage with respect to accidents occurring within that state. This special coverage is underwritten by a Motor Vehicle Accident Indemnification Corporation managed by the insurers authorized to write motor-vehicle-liability insurance in New York and supported by assessments levied on insurers and self-insurers. The MVAIC also protects residents who are not insured and who at the time of the accident are not

operating an uninsured vehicle.[15] Uninsured-motorists coverage for accidents outside the state is voluntary. Massachusetts and North Carolina each require that automobile insurers operating in their state include uninsured-motorists coverage in all their contracts unless the insured rejects this coverage.

Opponents, particularly insurers, also observe that people become more claims-conscious and courts more liberal when they know that every driver and owner is supposed to be insured. They point to the enforcement difficulties and expenses incurred in the three states that currently require all registered cars to be insured. Insurers object to having a state review board force them to insure people they would prefer to reject, but some review process is necessary because denial of insurance is, except for those with other financial resources, denial of the right to drive. Insurers also associate compulsory automobile insurance with inadequate rates. Insurers have suffered underwriting losses in Massachusetts during the period, taken as a whole, since 1927 when the Massachusetts law went into effect. Insurers also report that it has been more difficult to get requests for rate increases approved in New York since 1957 and in North Carolina since 1958, when the laws of these two states became effective. They blame increased political pressures upon the state insurance departments. Finally, they believe that compulsory automobile insurance is an unwarranted interference with voluntary action and they fear that compulsory automobile insurance will lead eventually to a demand for a competitive or monopoly state fund.

Proponents of compulsory automobile insurance either deny these assertions, e.g., the denial of rate increases on political grounds or the threat of a state fund, or argue that these are minor matters relative to the benefits afforded by this approach. The debate continues, but no state has acted for over a decade.

AUTOMOBILE-COMPENSATION PROPOSALS

Recently more radical proposals to abandon or modify the tort system for handling automobile claims have attracted more attention than has compulsory automobile insurance. These proposals have been stimulated by the criticisms of the present system noted on pp. 619–620. Such proposals are not new, but the mounting costs of automobile accidents and the changes in the social, political, and economic climate have granted them a more receptive audience than greeted the original proposals. The newer proposals have also

[15] Residents of Maryland, New Jersey, and two Canadian provinces are also covered by the MVAIC because of reciprocal agreements with the unsatisfied-judgments funds in those states.

benefited from earlier mistakes, and their proponents have devoted countless hours toward developing and selling their ideas. Nevertheless, no state has adopted any of these suggestions.

Credit for the first carefully worked-out proposal of this sort is usually given to a Columbia University study team whose 1932 proposal became known as the Columbia Plan.[16] This plan, like workmen's compensation, would have imposed upon the owners of motor vehicles absolute liability for personal injuries caused by the operation of their motor vehicles. The amount of that liability was to be determined by a schedule similar to that used in workmen's compensation, and the scheduled benefit was to be the exclusive remedy of the injured party. In other words, all common-law remedies were to be abolished. In the case of a two-car accident, the injured victims in each car would collect from the owner of the car in which they were riding.[17] Owners would be required to purchase insurance to cover their potential liability under the plan. A special board would be created to administer this system. The plan was bitterly opposed on many grounds, chief of which were the objections noted earlier with respect to compulsory automobile insurance, the reluctance to abandon the law of negligence because of its alleged ability to punish the guilty and deter negligence, the potential cost of the program, the inadequacy of the benefits proposed, the difficulties inherent in devising one schedule of benefits for victims of much more widely varying means and need (e.g., housewives and skilled surgeons) than is true under workmen's compensation, and the absence of controls over driving habits analogous to employer controls over workmen. Insurers and lawyers were the most active opponents of the proposal.

Although no state in the United States ever adopted the Columbia Plan, one Canadian province—Saskatchewan—enacted a modified version of this law in 1946. The principal modifications are that (1) victims can obtain damages in addition to the scheduled benefits from the compensation plan by pursuing a common-law action based upon negligence and (2) compulsory insurance against the compensation benefits and liability claims in excess of those benefits must be purchased from the Saskatchewan Government Insurance Office, a monopoly government insurer. The Saskatchewan experiment has been observed with great interest, but Saskatchewan is a rural, isolated area whose experience may not be relevant to any state in the United States. Some writers have observed that although the opportunity to pursue a claim

[16] See "Report of the Committee to Study Compensation for Automobile Accidents to the Columbia University Council for Research in the Social Sciences."

[17] Because of constitutional considerations that are probably no longer valid, each owner, however, would have collected from the other owner, if any. Robert Keeton and Jeffrey O'Connell, "Basic Protection for the Traffic Victim," pp. 134–135.

based on negligence helps to solve the problem of low compensation benefits, it might encourage negligence actions, which would include pain and suffering, because the victim has nothing to lose.[18]

More recent compensation proposals[19] include (1) Compulsory Comprehensive Loss Insurance, developed by Professor Leon Green, of the University of Texas Law School, which would require the payment of all out-of-pocket losses (not pain and suffering) up to some high limits; (2) "Full Aid" Insurance for the Traffic Victim, proposed by Professor Albert Ehrenzweig, of the University of California Law School at Berkeley, which would relieve those who voluntarily purchase insurance providing scheduled benefits on a compensation basis from common-law liability for ordinary (but not criminal) negligence; and (3) Supplementary Compensation in Economic Disaster Cases, presented by Professors Clarence Morris and James Paul, which would provide through a private or public fund compensation for out-of-pocket costs (not pain and suffering) when the medical expenses and earning losses not reimbursed by other sources such as private health insurance exceed some specified amount such as $800. A modified tort remedy would remain for smaller losses. The last two proposals were based on the conviction that complete abolition of the tort remedy was doomed to failure.

The proposal attracting the most attention currently is the Basic Protection Plan developed by Professor Robert Keeton, of the Harvard Law School, and Professor Jeffrey O'Connell, of the University of Illinois Law School. The product of years of research, the authors of this plan attempted to build upon earlier proposals. The basic features of the plan may be summarized as follows:[20]

1 Compulsory basic-protection insurance will compensate all persons injured in automobile accidents, regardless of fault. Pedestrians will collect from the insurer of the car that injures them. Occupants of a car will collect from the insurer of that car.

2 Compensation benefits will cover net economic losses only—primarily medical expenses and work loss (loss of earnings and the expenses of hiring someone else to provide services, normally household services, ordinarily provided by the injured party)—not pain and suffering. Property losses are not covered, but the plan could be modified to provide this protection.

3 Net economic losses are determined by subtracting from the gross losses (1) 15 per cent of any income loss to allow for tax savings and reduction

[18] *Ibid.*, p. 147.

[19] For a description of these and other proposals, see *ibid.*, pp. 148–189.

[20] The complete plan is presented in *ibid.*, pp. 273–514. For a summary, see R. E. Keeton and J. O'Connell, "Basic Protection—A New Plan of Automobile Insurance."

in work expenses, (2) reimbursement from other sources such as private life and health insurance, and (3) a deductible equal to $100 or, if higher, 10 per cent of the work loss. To illustrate, if the victim suffers a loss of $5,000 in medical expenses and $4,000 in earnings, his recovery, assuming a $2,000 recovery under private health insurance, would be $9,000 − 0.15 ($4,000) − $2,000 − 0.10 ($4,000) = $6,000.

4 The maximum benefit is $10,000 per person and $100,000 per accident, but if the accident claims exceed $100,000, provision is made for recovery from an assigned-claims plan. Work-loss benefits are also limited to $750 per month.

5 Benefits are not paid in one lump sum but instead are usually payable monthly as losses accrue.

6 If tort damages for pain and suffering would exceed $5,000 or if other tort damages would exceed $10,000, the injured victim may start a tort action. Any recovery, however, is reduced by these amounts.

7 Private insurers write the necessary insurance and an assigned-case plan is established to provide benefits when the vehicle is uninsured or a hit-and-run car.

Professors Keeton and O'Connell argue that their plan will replace the shortcomings of the present system with respect to benefit adequacy, equity, and promptness. It will reduce significantly the wastes of litigation but preserves the tort remedy for those with serious losses. They believe that it properly treats automobile losses as a cost of motoring generally. Merit rating could be included, if this seemed desirable, to punish the guilty and to deter negligent driving. One unique feature of their study is that it includes a draft of the statute necessary to introduce the plan. Frank Harwayne, a highly respected actuary, has estimated that Basic Protection Plan premiums in New York and in Michigan in recent years would have been less than premiums for typical automobile liability insurance.[21] More persons would collect benefits, but the average benefit would have been considerably less because it would contain no allowance for pain and suffering and would be subject to various deductions.

The plan, however, has been severely criticized in some quarters. Many critics deny that the present system has as many shortcomings or that they are as serious as those described on pp. 619–620.[22] They recognize that some shortcomings do exist, but they prefer reformation of the present system

[21] See Frank Harwayne, "Insurance Cost of Automobile Basic Protection Plan in Relation to Automobile Bodily Injury Liability Costs." See also the discussions of this paper and the author's reply, pp. 159–184.

[22] Two excellent statements of this counter position can be found in (1) Blum and Kalven, "Public Law Perspectives on a Private Law Problem—"Auto Compensation Plans," and (2) James S. Kemper, Jr., "The Keeton-O'Connell Plan: Reform or Regression."

to adopting a new, untried approach. They believe that the Basic Protection Plan would be more costly than its authors suggest and that it is almost impossible at this time to determine the relative cost of the plan by actuarial methods. They note that the plaintiff often loses in court and that many current disputes involve the amount of the damages, not whether any liability is involved. The Basic Protection Plan, they maintain, will not remove arguments on this phase of the claim. They ask whether eliminating the fault concept might affect drivers' attitudes adversely. Moreover, they argue, some allowance for pain and suffering is legitimate, even in the less serious cases. They emphasize the many differences between automobile accidents and industrial accidents, and they ask why automobile accidents, but not hunting or boating accidents or product liability claims, should be singled out for compensation treatment. The deduction of benefits from other sources in their opinion penalizes those who have the foresight to protect themselves. If, to counteract this effect, these outside sources took steps to excuse themselves from payments in basic-protection cases, this would increase the cost of the plan. Finally, they point out that if prices are to be related to expected losses and expenses, many drivers who are now considered substandard because of their high loss potential will pay lower rates because their passengers tend to suffer smaller economic losses. On the other hand, some drivers who currently pay relatively low rates would have their rates increased because the passengers tend to suffer higher economic losses.

The Keeton-O'Connell plan and similar proposals have been successfully opposed to date on grounds that are both selfish and unselfish, justified and unjustified.[23] Their principal progress to date is the fact that they have attracted increasing public attention. No longer are they ivory-tower dreams of interest to only a small group.

Position of Insurers

Some insurers are strong supporters of automobile compensation proposals while others are violently opposed. Many have adopted a "wait-and-see" attitude. In October, 1968 the American Insurance Association proposed a compensation plan that would abolish the tort system with respect to bodily injury claims. Among the strongest opponents of this proposal and the Basic Protection Plan are the National Association of Independent Insurers and the American Mutual Insurance Alliance.

[23] In 1967 the Massachusetts House passed a bill that would have put the Keeton-O'Connell plan into effect in that state by an overwhelming margin, but the Senate defeated the proposal. The governor had also indicated his intention to veto the bill.

Several other states have legislative and executive commissions studying the present and proposed systems for handling automobile-accident costs.

In late 1967 member insurers of the Alliance announced that they would shortly offer on an experimental basis in certain areas a "guaranteed benefits program" that would provide some benefits to all victims of automobile accidents. Under this program insurers pay medical expenses up to $5,000, without regard to fault. Injured parties can also elect to receive up to $7,500, regardless of fault, for income losses and other damages if they agree not to seek a settlement under the law of negligence. Victims in one-car accidents collect from the insurer of that car. Victims in two-car accidents collect from the insurer of the other car. At this writing several members of the Alliance, together with some leading stock insurers, are testing the program in two Illinois counties near Chicago and in two counties in the Rochester-Syracuse area of New York State. The results of this experiment will be observed with great interest by those persons who see some merits in the Basic Protection Plan but who prefer not to change the existing legal system.[24]

Two Important Recent Developments

In 1968 the Puerto Rican Legislature enacted into law a Social Protection Plan designed by Professors Juan Aponte and Herbert S. Denenberg of the University of Pennsylvania which provides tax-supported medical expense, disability, and death benefits to all motor-traffic victims. Tort liability, which can be insured with private insurers, still applies to losses in excess of $3,500 on account of pain and suffering and $7,000 on account of other damages.[25]

On May 22 President Johnson signed into law P.L. 90-313, which authorizes a two-year detailed study of the automobile-insurance business under the direction of the Secretary of Transportation. Although the study will deal with many problems, such as alleged underwriting restrictions and excessive and unwarranted cancellations, assigned-risk plans, insurer insolvencies, rising insurance costs, and imperfections in the regulation of automobile insurers, the investigators are expected to devote a major part of their efforts to automobile-compensation proposals.

QUESTIONS

1 In a typical state must a person have insurance in order to operate an automobile? If not, what type of action has the state taken to protect the public against uninsured motorists?

[24] See "Guaranteed Benefits: A Progress Report," pp. 1–4.

[25] Juan B. Aponte and Herbert S. Denenberg, "The Automobile Problem in Puerto Rico: Dimensions and Proposed Solutions."

2 Jones is hit by an uninsured driver and is unable to recover damages. What remedy is available to him if he lives in a state with an unsatisfied-judgments fund? How does this remedy compare with that under private uninsured-motorists coverage?

3 **a** Evaluate the argument that states with compulsory automobile insurance do not protect injured victims against hit-and-run drivers.

b What are the other arguments for and against compulsory automobile insurance?

4 Describe briefly the Keeton-O'Connell proposal. Do you favor this proposal? Why?

5 Which of the approaches discussed do you favor? Why?

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Sources of Information[1]

PRIMARY

Offices of Insurance Commissioners. The annual reports of admitted insurers are filed in the office of the insurance commissioner as public documents. They are open to inspection, and members of the staff will usually assist in their interpretation.

In some states reports of examinations (audits) of insurers are also public documents and similarly open to inspection. The laws of some states require that, for a time at least, examination findings be held confidential.

The office usually has the published annual reports of the insurance commissioners of other states from which information about insurers not admitted to the state may be obtained. The commissioner usually also receives the published material described below as secondary sources. In some offices this material is so filed that visitors may consult it, but it is generally regarded as working material and may not be kept readily at hand for visitors' use.

A citizen unable to visit the office may obtain by correspondence a digest of the data filed by any admitted insurer and other information about insurance. The office will not give opinions on comparative merits of licensed insurers.

Annual Reports of the Insurance Commissioner. In nearly all states the insurance commissioner prepares and publishes an annual report to the Governor or legislature. The report usually includes summary tables and textual comment on the year under review and, in condensed form, copies of the annual reports of admitted insurers. This report is available in the state library and usually in other public and private libraries.

Insurer Publications. Many insurers send annual reports to their insureds. These reports consist of condensations of their annual reports to the insurance commissioners with explanatory comments on them and on general conditions affecting the insurer.

Many insurers publish periodical house organs.

Both these sources of information are *primary*, but the reader must recognize that they are *neither independent nor disinterested.*

SECONDARY

"Best's Fire and Casualty Aggregates and Averages," annual. Data showing experience of individual insurers, insurer groups, and classes of insurer for the latest year and for longer periods.

"Best's Insurance Guide with Key Ratings," annual. Principally devoted to financial and operating data of insurers other than life over the latest five-year period. Each insurer is given a "policyholder's" and a "financial" rating.

[1] This compilation of sources of information is suggestive rather than exhaustive. It does not include textbooks.

"Best's Insurance Reports, Fire and Casualty"; "Best's Life Insurance Reports," Alfred M. Best Company, Inc.; Park Ave., Morristown, N.J. 07960, annual. Condensed annual figures for each insurer doing business in the United States, with a list of officers and directors, a brief historical sketch, the territory in which it operates, and the lines of business written. Significant ratios are presented and commented upon. Insurers are rated according to certain financial criteria.

"Cyclopedia of Insurance in the United States," The Index Publishing Company, 327 Totowa Ave., Paterson, N.J. 07502, annual. Data on insurers and insurer organizations, court decisions and opinions, definitions of terms, and biographical sketches.

"The Insurance Almanac," The Underwriter Printing and Publishing Company, 115 John St., New York 10038, annual. Brief explanations of covers; directories of agents, brokers, actuaries, adjusters, and state officials; data on insurers and insurer organizations; and miscellaneous information.

"Insurance by States of Property, Liability, Surety and Miscellaneous Lines," Chilton Company, Chestnut and 56th Sts., Philadelphia 19139, annual. Premium and loss data by lines of insurance (other than life), by insurers, and by states.

"Insurance Facts," Insurance Information Institute, 110 William St., New York 10038, annual. Selected data of general interest relating to property and liability insurance.

"Life Insurance Fact Book," Institute of Life Insurance, 277 Park Ave., New York 10017, annual. A wide variety of useful data on life insurance.

"Source Book of Health Insurance Data," Health Insurance Institute, 277 Park Ave., New York 10017, annual. Information on premiums, losses, medical-care costs, and other matters related to health insurance.

"The Spectator Life Insurance Year Book," Chilton Company, annual. Financial and other data on individual insurers and general historical and aggregate data.

SERVICES AND MANUALS

Fire, Casualty and Surety Bulletins, National Underwriter Company, 420 East 4th St., Cincinnati 45202, revised monthly. Policy forms, endorsements, and underwriting rules for practically all kinds of insurance except life and disability. Nonstandard coverages and unusual coverages are now discussed in detail in one volume.

Insurance Buyer's Guide, Cudahy Publishing Company, 6141 North Cicero Ave., Chicago 60646, monthly. A monthly newsletter discussing the problems of the risk manager.

Insurance Literature, Insurance Division, Special Libraries Association, monthly. Lists new insurance books and other materials, with occasional annotations.

The John Liner Letter, Shelby Publishing Corporation, Wellesley Office Park, Wellesley Hills 20181. A monthly business-insurance advisory service.

Rough Notes Policy, Form, and Manual Analyses, The Rough Notes Company, 1142 N. Meridian St., Indianapolis 46206, revised monthly. Forms and practices in fire, casualty, and surety lines.

Time Saver, National Underwriter Company, annual. An analysis of the policies and rates of most health insurers.

These following four manuals reproduce or digest the principal forms of life-insurance contracts of each insurer and include tables of rates, nonforfeiture values, etc. The "Unique Manual" has certain financial and miscellaneous data on life insurers.

"Flitcraft Compend," Flitcraft, Inc., P. O. Box 600, Morristown, N.J. 07960, annual.

"Little Gem Life Chart," National Underwriter Company, annual.

"The Spectator Handy Guide," Chilton Company, Chestnut and 56th Sts., Philadelphia 19139, annual.

"The Unique Manual and National Underwriter Life Reports," National Underwriter Company, annual.

PERIODICALS

The American Agency Bulletin, National Association of Insurance Agents, Inc., 3rd & Hunting Park Ave., Philadelphia 19140, monthly. Organ of the association. News of particular interest to insurance agents selling insurance other than life. Some articles of general interest.

The Annals, The Society of Chartered Property and Casualty Underwriters, 201 Penn State Building, Media, Pa. 19063, quarterly. Organ of the society. Feature articles on property and liability insurance.

Best's Insurance News. 2 eds., *Fire and Casualty* and *Life.* Alfred M. Best Company, Inc., Park Avenue, Morristown, N.J. 07960, monthly. Financial news and reports on individual insurers, articles on insurance questions.

Business Insurance, Advertising Publications, Inc., 740 Rush St., Chicago 60611, weekly. News and feature articles of interest to buyers of employee-benefit, property, and liability protection.

Insurance, Vantage Enterprises, Inc., 232 Madison Ave., New York 10016, weekly. General news and feature articles on all branches of insurance. Contains an insurance-periodicals index.

The Insurance Broker-Age, The Broker-Age, Inc., 90 John St., New York

10038, monthly. Organ of The Insurance Brokers' Association of the State of New York, Inc. Articles and news of special interest to brokers.

The Insurance Law Journal, Commerce Clearing House, Inc., 4025 West Peterson Ave., Chicago 60646, monthly. News and discussion of decisions, legislation, and administrative rulings.

Journal of American Insurance, American Mutual Insurance Alliance, 20 N. Wacker Dr., Chicago 60606, monthly. Articles on insurance subjects.

The Journal of the American Society of Chartered Life Underwriters, The American Society of Chartered Life Underwriters, 270 Bryn Mawr Ave., Bryn Mawr, Pa., 19010, quarterly. Organ of the society. Feature articles on life and health insurance.

The Journal of Insurance Information, Insurance Information Institute, 110 William St., New York 10038, monthly. Articles on property and liability insurance.

The Journal of Risk and Insurance, American Risk and Insurance Association, 210 E. University Ave., Bloomington, Ill. 61701, quarterly. Journal of the association. Scholarly articles by academic members, nonacademic members, and others.

The National Insurance Buyer, American Society of Insurance Management, Inc., 8 West 40th St., New York 10018, bimonthly. Organ of the society. News and articles of special interest to risk managers.

The National Underwriter, Fire and Casualty Edition and *Life Edition,* National Underwriter Company, 420 E. 4th St., Cincinnati 45202, weekly. General insurance news and occasional articles; broad national coverage.

Rough Notes, The Rough Notes Company, 1142 North Meridian St., Indianapolis 46206, monthly. News and articles on fire, casualty, and surety fields.

The Spectator, Chilton Company, Chestnut and 56th St., Philadelphia 19139, monthly. News, articles, and statistical data on all kinds of insurance.

United States Investor, Frank P. Bennett and Company, Inc., 286 Congress St., Boston 02210, weekly. Primarily a banking magazine. The insurance section features provocative articles by the insurance editor. Brief insurance items. Insurance-inquiry section.

The Weekly Underwriter, The Underwriter Printing and Publishing Company, 116 John St., New York 10038, weekly. Special departments by kinds of insurance. Educational articles and digests of court opinions.

DAILY PAPER

The Journal of Commerce, Twin Coast Newspapers, Inc., 99 Wall St., New York 10005. Insurance section contains national news and occasional feature articles. Annual insurance review.

The Wall Street Journal, 30 Broad St., New York 10004. Occasional feature articles and news stories about insurance.

LIBRARIES

Special insurance libraries are maintained in many centers by insurance organizations or by individual insurers. Especially useful libraries are those of the following organizations:

Insurance Educational Association, 660 Sacramento St., San Francisco 94111.

Insurance Library Association of Atlanta, Ga., 24 Ivy Street N.E., Atlanta 30303.

The Insurance Library Association of Boston, 89 Broad St., Boston 02110.

Insurance Library of Chicago, 175 W. Jackson Blvd., Chicago 60604.

Insurance Society of New York, Inc., 150 William St., New York 10038.

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